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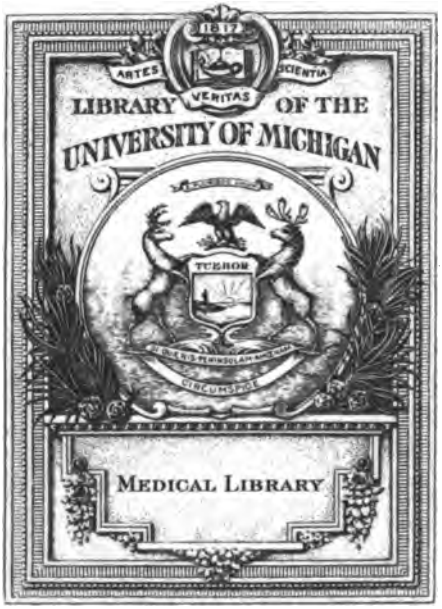
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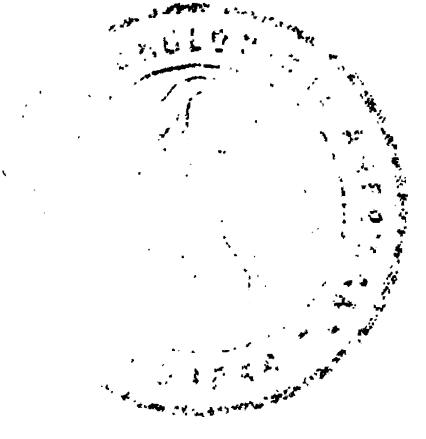
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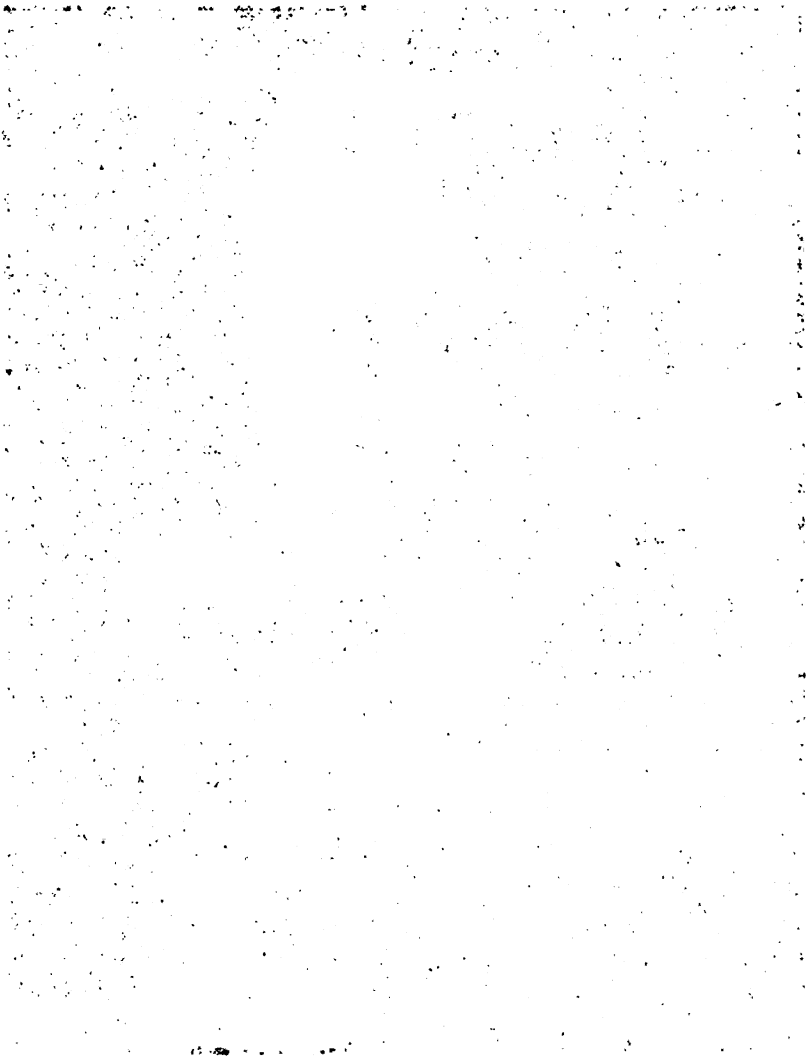
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PROCEEDINGS

OF THE

American Medico-Psychological Association

AT THE

SEVENTY-THIRD ANNUAL MEETING

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LIST OF MEMBERS

—OF THE—

AMERICAN MEDICO-PSYCHOLOGICAL ASSOCIATION

March, 1918

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1895 **Abbot, E. Stanley, M. D.,** Assistant Physician McLean Hospital, Waverley, Mass.

1907 **Abbot, Florence Hale, M. D.,** Assistant Physician Boston State Hospital, Dorchester Center, Mass.

1917 **Adams, Felix M., M. D.,** Superintendent East Oklahoma Hospital, Vinita, Okla.

1904 **Adams, Geo. Sheldon, M. D.,** Assistant Superintendent South Dakota Hospital for the Insane, Yankton, S. D.

1914 **Adler, Herman M., M. D.,** Director Juvenile Institute, Chicago, Ill.

1917 **Alford, DeLand B., M. D.,** Psychopathic Hospital, Boston, Mass. (*Associate.*)

1903 **Allen, Charles Lewis, M. D.,** Los Angeles, Cal.

1912 **Allen, Frederick E., M. D.,** Physician-in-Charge Elmwoods Sanitarium, Llewellyn Road, Hayward, Cal.

1893 **Allen, Henry D., M. D.,** Superintendent Invalids Home, Milledgeville, Ga.

1913 **Allen, J. Berton, M. D.,** Assistant Physician Central Islip State Hospital, Central Islip, N. Y.

1912 **Allison, W. L., M. D.,** Superintendent Arlington Heights Sanitarium, Fort Worth, Tex.

1913 **Alspaugh, Paul J., M. D.,** First Assistant Physician Massillon State Hospital, Massillon, O.

1913 **Amsden, George S., M. D.,** Assistant Physician Bloomingdale Hospital, White Plains, N. Y. (*Associate.*)

1915 **Anderson, Albert, M. D.,** Superintendent State Hospital, Raleigh, N. C.

1915 **Anderson, Paul V., M. D.,** Resident Physician Westbrook Sanatorium, Richmond, Va.

1916 **Anderson, Victor V., M. D.,** Psychologist Municipal Courts, Boston, Mass. (*Associate.*)

1894 **Anglin, James V., M. D.,** Medical Superintendent The Provincial Hospital, St. John, New Brunswick. (*President, 1918.*)

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1895 **Applegate, Charles F., M. D.,** Medical Superintendent Mt. Pleasant State Hospital, Mt. Pleasant, Ia.

1903 **Armstrong, George G., M. D.,** Senior Assistant Physician Buffalo State Hospital, Buffalo, N. Y. (*Associate.*)

1913 **Armstrong, Samuel T., M. D.,** Physician-in-Charge Hillbourne Club, Katonah, N. Y.

1904 **Ashley, Maurice C., M. D.,** Medical Superintendent Middletown State Homeopathic Hospital, Middletown, N. Y.

1890 **Atwood, Charles E., M. D.,** 14 E. 60th St., New York, N. Y.

1916 **Austin, Annie, M. D.,** Assistant Physician Hospital for Insane, Columbia, S. C. (*Associate.*)

B

1911 **Baber, Armitage, M. D.,** Superintendent Dayton State Hospital, Dayton, O.

1915 **Bachelder, Frank S., M. D.,** Assistant Superintendent Pontiac State Hospital, Pontiac, Mich. (*Associate.*)

1913 **Baker, Amos T., M. D.,** Associate Physician, West Hill, 261st St. & Broadway, New York, N. Y. (*Associate.*)

1904 **Baker, Benjamin W., M. D.,** Superintendent New Hampshire School for Feeble-Minded Children, Laconia, N. H.

1909 **Baldwin, Louis B., M. D.,** Superintendent University Hospital, University of Minnesota, Minneapolis, Minn.

1917 **Ball, Charles R., M. D.,** 1044 Lowry Bldg., St. Paul, Minn.

1916 **Ball, Jau Don, M. D.,** Oakland, Cal.

1898 **Ballintine, Eveline P., M. D.,** Assistant Physician Rochester State Hospital, Rochester, N. Y. (*Associate.*)

1896 **Bamford, Thos. E., M. D.,** 304 Delaware St., Syracuse, N. Y.

1883 **Bancroft, Chas. P., M. D.,** Concord, N. H. (*President, 1908.*)

1890 **Bannister, Henry M., M. D.** (formerly Assistant Physician Illinois Eastern Hospital for the Insane), 828 Judson Ave., Evanston, Ill. (*Honorary.*)

1915 **Bannon, Freeman R., M. D.,** Bloomingdale, Ind. (*Associate.*)

1912 **Barber, Bruce B., M. D.,** Assistant Physician Columbus State Hospital, Columbus, O. (*Associate.*)

1914 **Barber, W. C., M. D.,** Superintendent Simcoe Hall, Barrie, Ont., Canada.

1913 **Barlow, Charles A., M. D.,** Tampa, Fla., Box 1471.

1912 **Barnes, E. C., M. D.,** Assistant Physician Homewood Sanitarium. Guelph, Ont. (*Associate.*)

1909 **Barnes, Francis M., Jr., M. D.,** 306 Humboldt Bldg., St. Louis, Mo.

1914 **Barnhardt, Wm. N., M. D.,** Assistant Physician Central Islip State Hospital, Central Islip, N. Y. (*Associate.*)

1898 **Barrett, Albert M., M. D.,** Professor of Psychiatry and Neurology University Hospital, Ann Arbor, Mich.

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1916 **Barrett, Thos. S., M. D.,** Assistant Physician Dixmont Hospital, Dixmont, Pa. (*Associate.*)

1914 **Barry, R. Grant, M. D.,** Assistant Physician New Jersey State Hospital, Trenton, N. J. (*Associate.*)

1912 **Bartram, Nell W., M. D.,** Assistant Physician Kings Park State Hospital, Kings Park, N. Y. (*Associate.*)

1914 **Baskett, George T., M. D.,** Assistant Superintendent St. Peter State Hospital, St. Peter, Minn.

1913 **Bass, T. B., M. D.,** Superintendent Texas State Epileptic Colony, Abilene, Tex.

1909 **Beach, Lena A., M. D.,** Cherokee, Iowa.

1900 **Becker, W. F., M. D.,** Consulting Neurologist Milwaukee County Hospital, 604 Goldsmith Building, Milwaukee, Wis.

1892 **Beemer, Nelson H., M. D.,** Superintendent Mimico Hospital for the Insane, Toronto, Ont.

1902 **Beling, Christopher C., M. D.** (formerly Assistant Physician New Jersey State Hospital, Morris Plains, N. J.), 109 Clinton Ave., Newark, N. J.

1913 **Bellinger, Clarence H., M. D.,** Assistant Physician Binghamton State Hospital, Binghamton, N. Y. (*Associate.*)

1915 **Bentley, Inez A., M. D.,** Woman Physician Kings Park State Hospital, Kings Park, N. Y. (*Associate.*)

1893 **Berkley, Henry J., M. D.,** 1305 Park Ave., Baltimore, Md.

1904 **Betts, Joseph B., M. D.,** Assistant Physician Buffalo State Hospital, Buffalo, N. Y. (*Associate.*)

1899 **Beutler, W. F., M. D.,** Medical Superintendent Milwaukee Asylum for the Chronic Insane, Wauwatosa, Wis.

1913 **Blaisdell, Russell E., M. D.,** Assistant Physician Kings Park State Hospital, Kings Park, N. Y. (*Associate.*)

1914 **Blauvelt, John H., M. D.,** Assistant Physician Matteawan State Hospital, Beacon, N. Y. (*Associate.*)

1917 **Bledsoe, Edwin P., M. D.,** Little Rock, Ark.

1916 **Bliss, Geo. S., M. D.,** Superintendent School for Feeble-Minded Youth, Ft. Wayne, Ind.

1912 **Bloss, James R., M. D.,** P. O. Box 453, Huntington, W. Va. (*Associate.*)

1886 **Blumer, G. Alder, M. D.,** Medical Superintendent Butler Hospital, Providence, R. I. (*President, 1903.*)

1909 **Bond, Earl D., M. D.,** Senior Assistant Physician Pennsylvania Hospital, Department for Mental and Nervous Diseases, West Philadelphia, Pa.

1907 **Bond, George F. M., M. D.,** Proprietor Dr. Bond's House, 960 N. Broadway, Yonkers, N. Y.

1892 **Bondurant, Eugene D., M. D.** (formerly Assistant Superintendent Alabama Bryce Hospital), 166 Conti St., Mobile, Ala.

1913 **Borden, P. G., M. D.,** M. R. C., U. S. Army. (*Associate.*)

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1917 **Bowman, Carl Murdock, M. D.**, Assistant Physician Bloomingdale Hospital, White Plains, N. Y. (*Associate.*)

1912 **Boyd, Wm. A., M. D.**, Schofield Barracks, Hawaii.

1904 **Bradley, Isabel A., M. D.**, 221 Ash St., Akron, O.

1914 **Braunlin, Edgar L., M. D.**, First Assistant Physician Dayton State Hospital, Dayton, O.

1916 **Brewster, David T., M. D.**, Assistant Physician Hudson River State Hospital, Poughkeepsie, N. Y. (*Associate.*)

1910 **Brewster, George F., M. D.**, 264 W. 57th St., New York, N. Y.

1907 **Briggs, L. Vernon, M. D.**, 64 Beacon St., Boston, Mass. U. S. Army.

1913 **Brill, A. A., M. D.**, 1 W. 70th St., New York, N. Y.

1906 **Brochu, M. D., M. D.**, Superintendent Beauport Asylum for Insane, Beauport, Que.

1915 **Brodsky, Emanuel S., M. D.**, Assistant Superintendent Westport Sanatorium, Westport, Conn. (*Associate.*)

1910 **Brooks, Swepson J., M. D.**, Physician-in-Charge St. Vincent's Retreat, Harrison, N. Y.

1914 **Brothers, J. E., M. D.**, Assistant Physician State Hospital, Goldsboro, N. C. (*Associate.*)

1913 **Brown, G. W., M. D.**, Superintendent Eastern State Hospital, Williamsburg, Va.

1917 **Brown, J. F. Leigh, M. D.**, Assistant Physician Verdun Hospital, Verdun, Que. (*Associate.*)

1914 **Brown, Louis R., M. D.**, Assistant Physician Hospital for Insane, Middletown, Conn. (*Associate.*)

1883 **Brown, Sanger, M. D.**, Physician-in-Chief Kenilworth Sanitarium, Kenilworth, Ill.

1913 **Brown, Sanger, II, M. D.**, Captain Surgeon General's Office, Washington, D. C. (*Associate.*)

1912 **Brown, Sherman, M. D.**, Superintendent Kenilworth Sanitarium, Kenilworth, Ill. (*Associate.*)

1899 **Brown, W. Stuart, M. D.**, Physician-in-Charge Sanford Hall, Flushing, New York, N. Y.

1899 **Brownrigg, Albert Edward, M. D.**, Medical Superintendent Highland Spring Sanatorium, Nashua, N. H.

1912 **Brundage, Howard M., M. D.**, 112 E. Broad St., Columbus, O.

1908 **Brunk, Oliver C., M. D.**, 405 E. Grace St., Richmond, Va.

1891 **Brush, Edward N., M. D.**, Physician-in-Chief and Superintendent Sheppard and Enoch Pratt Hospital, Towson, Md. (*President, 1916.*)

1912 **Bryan, Wm. A., M. D.**, Assistant Physician Cherokee State Hospital, Cherokee, Ia. (*Associate.*)

1895 **Bryant, Percy, M. D.** (formerly Medical Superintendent Male Department Manhattan (N. Y.) State Hospital), Bowdoin Park, Rahway, N. J.

1891 **Buchanan, J. M., M. D.**, Superintendent East Mississippi Insane Hospital, Meridian, Miss.

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1912 **Buckley, Albert C., M. D.,** Friends' Hospital, Frankford, Philadelphia, Pa. (*Associate.*)

1898 **Buckley, James M., D. D., LL. D.,** Morristown, N. J. (*Honorary.*)

1915 **Buell, Blinn A., M. D.,** Guilford, N. Y. (*Associate.*)

1902 **Bullard, E. L., M. D.** (formerly Superintendent Wisconsin State Hospital for the Insane, Mendota, Wis.), Proprietor and Physician-in-Charge Chestnut Lodge Sanitarium, Rockville, Md.

1905 **Burdick, Charles M., M. D.,** Senior Assistant Physician Central Islip State Hospital, Central Islip, L. I., N. Y. (*Associate.*)

1913 **Burdsall, Elijah S., M. D.,** Assistant Physician Middletown State Homeopathic Hospital, Middletown, N. Y. (*Associate.*)

1890 **Burgess, T. J. W., M. D.,** Medical Superintendent Protestant Hospital for the Insane, New P. O. Box 2280, Special Bag, Montreal, Que. (*President, 1905.*)

1909 **Burlingame, C. C., M. D.,** South Manchester, Conn. (*Associate.*)

1894 **Burnet, Anne, M. D.,** 513 La Salle St., Wausau, Wis.

1913 **Burnett, S. Grover, M. D.,** Medical Superintendent The Burnett Sanitarium, 3100 Euclid Ave., Kansas City, Mo.

1914 **Burns, Geoffrey C. H., M. D.,** Senior Assistant Physician Central Islip State Hospital, Central Islip, N. Y. (*Associate.*)

1890 **Burr, C. B., M. D.,** Medical Director Oak Grove Hospital, Flint, Mich. (*President, 1906.*)

1907 **Burr, Chas. W., M. D.,** Professor of Mental Diseases University of Pennsylvania, 1918 Spruce St., Philadelphia, Pa.

1917 **Burrier, Walter, M. D.,** Assistant Physician State Hospital, Medfield, Mass. (*Associate.*)

1901 **Busey, A. P., M. D.,** Superintendent Colorado State Home and Training School for Mental Defectives, Ridge, Colo.

1917 **Butler, Robert Morris, M. D.,** Superintendent State Insane Hospital, Jackson, Miss.

1910 **Butterfield, George K., M. D.,** Grafton State Hospital, Worcester, Mass. (*Associate.*)

C

1902 **Calder, Daniel H., M. D.,** Pasadena, Cal.

1917 **Campbell, Charles Macfie, M. D.,** Associate in Psychiatry Johns Hopkins Hospital, Baltimore, Md.

1907 **Campbell, Earl H., M. D.,** Superintendent Upper Peninsula Hospital for the Insane, Newberry, Mich.

1899 **Campbell, George B., M. D.,** First Assistant Physician Utica State Hospital, Utica, N. Y.

1885 **Campbell, Michael, M. D.,** Knoxville, Tenn.

1914 **Canavan, Myrtelle M., M. D.,** Assistant Pathologist Massachusetts Commission on Mental Diseases, Boston, Mass.

1901 **Caples, Byron M., M. D.,** Medical Superintendent Waukesha Springs Sanitarium, Waukesha, Wis.

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1909 **Capron, Arthur J., M. D.,** Physician-in-Charge Glenmary Sanitarium, Owego, N. Y.

1914 **Carey, Charles J., M. D.,** Superintendent Eastern Shore State Hospital, Cambridge, Md.

1905 **Carey, Harris May, M. D.,** P. O. Box 83, Odessa, Del.

1903 **Carlisle, Chester Lee, M. D.,** Superintendent Division of Mental Defectives, State Board of Charities, Albany, N. Y. (*Associate.*)

1915 **Carmichael, F. A., M. D.,** Superintendent Osawatomie State Hospital, Osawatomie, Kans.

1911 **Carpenter, Howard P., M. D.,** Assistant Physician Hudson River State Hospital, Poughkeepsie, N. Y. (*Associate.*)

1906 **Carriel, Henry B., M. D.,** Dixon State Colony, Dixon, Ill.

1911 **Carroll, Robert S., M. D.,** Medical Director Highland Hospital, Asheville, N. C.

1913 **Casamajor, Louis, M. D.,** 40 E. 41st St., New York, N. Y.

1909 **Cavanaugh, William J., M. D.,** Senior Assistant Physician Hudson River State Hospital, Poughkeepsie, N. Y. (*Associate.*)

1917 **Cazenavette, Lionel L., M. D.,** Visiting Physician to Charity Hospital, New Orleans, La.

1892 **Chaddock, Chas. G., M. D.,** 3705 Delmar Boulevard, St. Louis, Mo.

1896 **Chagnon, E. Philippe, M. D.,** 197 Esplanade Ave., Montreal, Que.

1880 **Channing, Walter, M. D.,** Channing Sanitarium, Brookline, Mass.

1912 **Chapman, Ross McC., M. D.,** St. Elizabeth Hospital, Washington, D. C.

1883 **Chase, Robert H., M. D.,** Medical Superintendent Friends' Hospital, Frankford, Philadelphia, Pa.

1914 **Cheney, Clarence O., M. D.,** Assistant Physician Manhattan State Hospital, Ward's Island, N. Y.

1912 **Child, Howard T., M. D.,** Pathologist Kankakee State Hospital, Kankakee, Ill. (*Associate.*)

1895 **Chilgren, G. A., M. D.,** 413 Iowa State Bank Bldg., Burlington, Iowa.

1892 **Christian, Edmund A., M. D.,** Medical Superintendent Pontiac State Hospital, Pontiac, Mich.

1916 **Church, Mary Violet, M. D.,** Assistant Physician Southern Indiana Hospital, Evansville, Ind. (*Associate.*)

1917 **Clark, Carolyn, M. D.,** Assistant Physician Southwestern State Hospital, Marion, Va. (*Associate.*)

1907 **Clark, Charles H., M. D.,** Superintendent Lima State Hospital, Lima, Ohio.

1910 **Clark, Fred P., M. D.,** Superintendent State Hospital, Stockton, Cal.

1915 **Clark, J. Henry, M. D.,** 12 Walnut St., Newark, N. J.

1898 **Clark, Joseph Clement, M. D.,** Superintendent Springfield State Hospital, Sykesville, Md.

1906 **Clark, L. Pierce, M. D.,** Consulting Neurologist Central Islip State Hospital, 128 E. 61st St., New York, N. Y.

1885 **Clarke, Chas. K., M. D.,** Medical Superintendent Toronto General Hospital, Toronto, Ont.

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1915 **Clarke, H. G., M. D.**, M. R. C., U. S. Army. (*Associate.*)
1904 **Clarke, Homer E., M. D.**, Assistant Medical Director, Oak Grove Hospital, Flint, Mich. (*Associate.*)
1917 **Cleaves, Helen Taft, M. D.**, Assistant Physician Monson State Hospital, Monson, Mass. (*Associate.*)
1915 **Cline, Bernard McHugh, M. D.**, Assistant Physician Georgia State Sanitarium, Milledgeville, Ga.
1915 **Cobb, O. H., M. D.**, Superintendent Syracuse State Hospital for Feeble-Minded Children, Syracuse, N. Y.
1898 **Coe, Henry W., M. D.**, Medical Director Morning Side Hospital, 516 Selling Building, Portland, Ore.
1915 **Coffin, Harriet F., M. D.**, Assistant Physician Kings Park State Hospital, Kings Park, N. Y. (*Associate.*)
1905 **Coggins, Jesse C., M. D.**, Medical Director The Laurel Sanitarium, Laurel, Md.
1913 **Cohn, Eugen, M. D.**, M. O. Kankakee State Hospital, Kankakee, Ill.
1913 **Cohoon, E. H., M. D.**, Superintendent Medfield State Hospital, Harding, Mass. (*Associate.*)
1901 **Coleburn, Arthur B., M. D.**, Capt. M. R. C., U. S. Army. (*Associate.*)
1909 **Collier, G. Kirby, M. D.**, Assistant Physician Craig Colony for Epileptics, Sonyea, N. Y.
1912 **Colnon, A. T., M. D.**, Assistant Physician St. Lawrence State Hospital, Ogdensburg, N. Y. (*Associate.*)
1915 **Conlon, Wm. Alfred, M. D.**, Assistant Physician Central Islip State Hospital, Central Islip, N. Y. (*Associate.*)
1917 **Conzelman, Fred, M. D.**, Clinical Director State Hospital, Stockton, Cal. (*Associate.*)
1894 **Cook, R. Harvey, M. D.**, Physician-in-Chief Oxford Retreat, Oxford, Ohio.
1894 **Cook, Robert G., M. D.**, Resident Physician Brigham Hall, Canandaigua, N. Y.
1915 **Cooper, A. S., M. D.**, Mansfield, La. (*Associate.*)
1892 **Copp, Owen, M. D.**, Physician-in-Chief and Superintendent Pennsylvania Hospital, Department for Nervous and Mental Diseases, West Philadelphia, Pa.
1912 **Corcoran, David, M. D.**, Assistant Physician Central Islip State Hospital, Central Islip, N. Y. (*Associate.*)
1914 **Corey, Herman W., M. D.**, Assistant Physician St. Peter State Hospital, St. Peter, Minn. (*Associate.*)
1903 **Coriat, Isador H., M. D.**, 416 Marlborough St., Boston, Mass.
1908 **Cornell, William B., M. D.**, Medical Director New York City Children's Hospital and School, Randalls Island, N. Y.
1915 **Cornwell, Herbert C. deV., M. D.**, Capt. M. R. C., U. S. Army.
1902 **Cort, Paul Lange, M. D.**, 144 W. State St., Trenton, N. J. (*Associate.*)
1903 **Cotton, Henry A., M. D.**, Medical Director New Jersey State Hospital, Trenton, N. J.

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1881 **Cowles, Edward, M. D.** (formerly Medical Superintendent McLean Hospital, Waverley), Plymouth, Mass. (*President, 1895.*)

1914 **Cozad, H. Irving, M. D.**, Clinical Director Fair Oaks Villa, Cuyahoga Falls, O. (*Associate.*)

1912 **Craig, Anna, M. D.**, Assistant Physician Kings Park State Hospital, Kings Park, N. Y. (*Associate.*)

1916 **Craig, Joseph S., M. D.**, Assistant Physician Southeastern Hospital, Richmond, Ind. M. R. C., U. S. Army. (*Associate.*)

1916 **Crenshaw, Hansell, M. D.**, Atlanta, Ga.

1908 **Crittenden, Samuel W., M. D.**, Assistant Director Commission on Mental Disease, State House, Boston, Mass. (*Associate.*)

1913 **Crooks, Wm. A., M. D.**, Rock Island, Ill.

1892 **Crumbacker, W. P., M. D.**, Medical Superintendent Independence State Hospital, Independence, Ia.

1917 **Cuddy, Thomas, M. D.**, Assistant Physician Channing Sanitarium, Wellesley, Mass. (*Associate.*)

1913 **Curry, Marcus A., M. D.**, Assistant Physician New Jersey State Hospital, Morris Plains, N. J. (*Associate.*)

1913 **Curtis, Barbara, M. D.**, Hudson River State Hospital, Poughkeepsie, N. Y. (*Associate.*)

D

1914 **Darling, Ira A., M. D.**, Assistant Physician State Hospital, Warren, Pa. (*Associate.*)

1899 **Darling, W. H., M. D.**, Superintendent The Sanatorium, Hudson, Wis. (*Associate.*)

1902 **Darnall, Rolland F., M. D.**, Clinical Director and Assistant Superintendent State Hospital for Nervous Diseases, Little Rock, Ark.

1915 **Darrow, Fred L., M. D.**, Assistant Physician Eastern Indiana Hospital, Richmond, Ind. M. R. C., U. S. Army. (*Associate.*)

1916 **Davidson, A. J., M. D.**, Assistant Physician Central State Hospital, Lakeland, Ky. (*Associate.*)

1913 **Davies, George W., M. D.**, Essex County Hospital for Insane, Cedar Grove, N. J. (*Associate.*)

1909 **De Jarnette, J. S., M. D.**, Medical Superintendent Western State Hospital, Staunton, Va.

1899 **Delacroix, Arthur C., M. D.**, Douglas, Alaska. (*Associate.*)

1913 **DeLaHoyde, T. Grover, M. D.**, Assistant Physician Norwalk State Hospital, Norwalk, Cal. (*Associate.*)

1916 **DeLand, Maude S., M. D.**, Assistant Physician Topeka State Hospital, Topeka, Kans. (*Associate.*)

1917 **DeMahy, Marcel J., M. D.**, Neurologist Town Infirmary, New Orleans, La.

1909 **Dennes, Blanche, M. D.**, Assistant Physician Hudson River State Hospital, Poughkeepsie, N. Y. (*Associate.*)

1915 **Deuschle, W. D., M. D.**, 112 E. Broad St., Columbus, Ohio.

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1915 **Devendorf, Frederick C., M. D.**, Assistant Physician Matteawan State Hospital, Beacon, N. Y. (*Associate.*)

1912 **Devlin, Francis E., M. D.**, Assistant Superintendent Hospital St. Jean de Dieu, Gamelin, Que. (*Associate.*)

1911 **De Weese, Cornelius, M. D.**, Medical Director The Laurel Sanitarium, Laurel, Md.

1890 **Dewey, Chas. G., M. D.**, Examining Physician Registration Department City of Boston, 44 Alban St., Dorchester, Boston, Mass.

1881 **Dewey, Richard, M. D.**, Physician-in-Charge Milwaukee Sanitarium, Wauwatosa, Wis. (*President, 1896.*) Chicago office, 34 Washington St., Marshall Field Annex Bldg., Wednesdays, 11.30 a. m. to 1 p. m.

1913 **Dexter, Roger, M. D.**, Assistant Physician Dannemora State Hospital, Dannemora, N. Y. (*Associate.*)

1900 **Diefendorf, Allen Ross, M. D.**, 29 College St., New Haven, Conn.

1912 **Dobson, Wm. M., M. D.**, Boston State Hospital, Dorchester Centre, Mass. (*Associate.*)

1912 **Dodge, Percy L., M. D.**, Assistant Physician Hudson River State Hospital, Poughkeepsie, N. Y. (*Associate.*)

1907 **Doherty, Charles E., M. D.**, Superintendent Public Hospital for Insane, New Westminster, B. C., Canada.

1892 **Dold, William E., M. D.**, Physician-in-Charge River Crest Sanitarium, Astoria, L. I., N. Y. 616 Madison Ave., New York City.

1908 **Dolloff, Charles H., M. D.**, Superintendent New Hampshire State Hospital, Concord, N. H. (*Associate.*)

1917 **Donnet, John V., M. D.**, Assistant Physician New Jersey State Hospital, Morris Plains, N. J. (*Associate.*)

1908 **Donohoe, George, M. D.**, Superintendent Cherokee State Hospital, Cherokee, Iowa.

1902 **Douglas, A. E., M. D.**, Superintendent Highland Sanitarium, R. F. D. No. 7, Nashville, Tenn.

1916 **Douglas, Gilbert F., M. D.**, M. R. C., U. S. Army, 26 W. 60th St., New York, N. Y. (*Associate.*)

1907 **Downing, Dana Fletcher, M. D.**, Assistant Physician Westborough State Hospital, Westborough, Mass.

1892 **Drewry, William F., M. D.**, Medical Superintendent Central State Hospital, Petersburg, Va. (*President, 1910.*)

1915 **Drysdale, H. H., M. D.**, Rose Bldg., Cleveland, Ohio.

1917 **Duke, John W., M. D.**, Chairman State Commission in Lunacy, Guthrie, Okla.

1914 **Dunham, Sydney A., M. D.**, Resident Physician and Proprietor Dr. Dunham's Sanitarium, 1392 Amherst St., Buffalo, N. Y.

1913 **Dunning, Ralph H., M. D.**, 2020 James St., Eastwood, N. Y. (*Associate.*)

1896 **Dunton, Wm. Rush, Jr., M. D.**, First Assistant Physician Sheppard and Enoch Pratt Hospital, Towson, Md.

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1912 **Durgin, Delmer D., M. D.,** Assistant Physician Kings Park State Hospital, Kings Park, N. Y. (*Associate.*)

1899 **Durham, Albert, M. D.,** Piedmont Bldg., Charlotte, N. C. (*Associate.*)

1917 **Dykman, Augustus B., M. D.,** Assistant Physician Hudson River State Hospital, Poughkeepsie, N. Y. (*Associate.*)

E

1909 **Earl, H. D., M. D.,** First Assistant Physician North Dakota State Hospital, Jamestown, N. D.

1912 **Eastman, Frederic C., M. D.,** 1268 Bergen St., Brooklyn, N. Y.

1912 **Eaton, Richard G., M. D.,** Assistant Physician Cherokee State Hospital, Cherokee, Ia. (*Associate.*)

1914 **Eckel, John L., M. D.,** 145 Allen St., Buffalo, N. Y.

1915 **Eckerdt, A. Burton, M. D.,** Assistant Physician Montana State Hospital, Warm Springs, Mont., care of P. O. Box 1657. (*Associate.*)

1896 **Edenharter, Geo. F., M. D.,** Medical Superintendent Central Indiana Hospital for the Insane, Indianapolis, Ind.

1893 **Edgerly, J. Frank, M. D.,** Lincoln, Mass.

1894 **Edwards, John B., M. D.** (formerly Medical Superintendent Wisconsin State Hospital), 311 Goldsmith Building, Milwaukee, Wis.

1917 **Eichelberger, William W., M. D.,** Evansville, Ind. (*Associate.*)

1913 **Eirley, Clara, M. D.,** State Hospital, St. Peter, Minn. (*Associate.*)

1897 **Elliott, Robert M., M. D.,** Medical Superintendent Willard State Hospital, Willard, N. Y.

1915 **Ellison, Wm. A., M. D.,** Assistant Physician Allens Invalid Home, Milledgeville, Ga. (*Associate.*)

1913 **Emerick, E. J., M. D.,** Superintendent Institution for Feeble-Minded, Columbus, O.

1913 **Emerson, Ernest B., M. D.,** Superintendent Rutland Sanatorium, Rutland, Mass.

1892 **Emerson, Justin E., M. D.,** care Paul E. Emerson, New York, N. Y.

1915 **Ende, Edward H., M. D.,** Assistant Physician Central Islip State Hospital, Central Islip, N. Y. (*Associate.*)

1917 **Engberg, Edward J., M. D.,** Teacher Nervous and Mental Diseases University of Minnesota, St. Paul, Minn.

1909 **English, W. M., M. D.,** Medical Superintendent Hospital for Insane, Hamilton, Ont.

1893 **Evans, B. D., M. D.,** Medical Director New Jersey State Hospital, Morris Plains, N. J.

1915 **Evans, T. W., M. D.,** Lieut. M. R. C., U. S. Army. (*Associate.*)

1914 **Evarts, Arrah B., M. D.,** Assistant Physician St. Elizabeth Hospital, Washington, D. C.

1908 **Everett, Edward A., M. D.,** Superintendent Cornwall Sanitarium, Cornwall-on-Hudson, N. Y.

1912 **Ewing, Hallie Laura, M. D.,** Assistant Physician Nebraska Hospital for Insane, Lincoln, Neb. (*Associate.*)

1892 **Eyman, H. C., M. D.,** Medical Superintendent Massillon State Hospital, Massillon, O. (*Secretary-Treasurer.*)

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F

1907 **Faison, W. W., M. D.,** Superintendent State Hospital, Goldsboro, N. C.
1917 **Farrington, Charlotte S., M. D.,** Philadelphia, Pa.
1916 **Farrington, E. A., M. D.,** Bancroft School for Feeble-Minded Youth, Haddonfield, N. J.
1912 **Faxon, Dora W., M. D.,** Boston State Hospital, Dorchester Center, Mass. (*Associate.*)
1916 **Fell, Egbert W., M. D.,** Assistant Physician Psychopathic Hospital, Kankakee, Ill. M. R. C., U. S. Army. (*Associate.*)
1898 **Felty, John C., M. D.,** 143 Baltimore St., Gettysburg, Pa. (*Associate.*)
1895 **Fernald, Walter E., M. D.,** Superintendent Massachusetts School for the Feeble-Minded, Waverley, Mass.
1909 **Ferris, Albert Warren, M. D.,** The Glen Springs, Watkins, N. Y.
1913 **Finlayson, Alan D., M. D.,** Senior Assistant Physician Warren State Hospital, Warren, Pa. (*Associate.*)
1915 **Fischbein, Elias, M. D.,** Assistant Physician Craig Colony for Epileptics, Sonyea, N. Y. (*Associate.*)
1912 **Fish, Drury L., M. D.,** Kankakee State Hospital, Hospital, Ill. (*Associate.*)
1907 **Fisher, E. Moore, M. D.,** Senior Assistant Physician New Jersey State Hospital, Morris Plains, N. J. (*Associate.*)
1892 **Fitzgerald, John F., M. D.,** General Medical Superintendent, King's County Hospital, Brooklyn, N. Y.
1912 **Fletcher, Christopher, M. D.,** Assistant Physician Buffalo State Hospital, Buffalo, N. Y. (*Associate.*)
1900 **Flood, Everett, M. D.,** Superintendent Monson State Hospital, Palmer, Mass.
1912 **Foley, Edward A., M. D.,** Assistant Physician State Hospital, Watertown, Ill. (*Associate.*)
1915 **Folsam, Ralph P., M. D.,** Senior Physician Manhattan State Hospital, Wards Island, N. Y. (*Associate.*)
1916 **Fongerousse, Henry L., M. D.,** Assistant Physician Louisiana Hospital for Insane, Pineville, La. (*Associate.*)
1916 **Ford, Walter A., M. D.,** Clinical Pathologist State Psychopathic Institute, Kankakee, Ill. (*Associate.*)
1911 **Fordyce, O. O., M. D.,** Superintendent Athens State Hospital, Athens, O.
1913 **Forster, James M., M. D.,** Medical Superintendent Hospital for Insane, Toronto, Ont.
1915 **Fort, S. J., M. D.,** Baltimore, Md.
1915 **Francisco, Howard M., M. D.,** M. R. C., U. S. Army. (*Associate.*)
1908 **Franz, Shepherd I., A. B., Ph. D.,** Scientific Director St. Elizabeth Hospital, Washington, D. C. (*Honorary.*)
1917 **Frazer, B. F., M. D.,** Assistant Physician Osawatomie State Hospital, Osawatomie, Kans. (*Associate.*)

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1913 **Freeman, George H., M. D.,** Superintendent State Hospital for Inebriates, Willmar, Minn.

1897 **French, Edward, M. D.,** 135 Cheswick Road, Brighton, Mass.

1914 **Frink, Horace W., M. D.,** 1 W. 83d St., New York, N. Y.

1913 **Fuller, Daniel H., M. D.,** Senior Assistant Physician Pennsylvania Hospital, Department for Mental and Nervous Diseases, West Philadelphia, Pa.

1902 **Fuller, Solomon Carter, M. D.,** Pathologist Westborough State Hospital, Westborough, Mass. (*Associate.*)

1916 **Fulmer, Joseph C., M. D.,** Assistant Physician Pennsylvania State Lunatic Hospital, Harrisburg, Pa. (*Associate.*)

1908 **Funkhouser, Edgar B., M. D.,** Second Assistant Physician New Jersey State Hospital, Trenton, N. J. (*Associate.*)

1914 **Furman, Isaac J., M. D.,** Assistant Physician Kings Park State Hospital, Kings Park, N. Y. (*Associate.*)

G

1917 **Gahagan, Henry J., M. D.,** 1448 Peoples Gas Bldg., Chicago, Ill.

1916 **Gaines, Lewis M., M. D.,** Atlanta, Ga.

1911 **Gale, George Bancroft, M. D.,** 457 Mt. Prospect Ave., Newark, N. J.

1913 **Gardner, Wm. E., M. D.,** Louisville Neuropathic Sanatorium, Louisville, Ky.

1900 **Garlick, J. H., M. D.,** First Assistant Physician Western State Hospital, Staunton, Va. (*Associate.*)

1905 **Garrett, R. Edward, M. D.,** Assistant Physician Maryland Hospital for the Insane, Catonsville, Md. (*Associate.*)

1915 **Garvin, Wm. C., M. D.,** Senior Assistant Physician Manhattan State Hospital, Wards Island, N. Y. (*Associate.*)

1909 **George, John Cecil, M. D.,** Orchard Springs Sanitarium, Dayton, Ohio. (*Associate.*)

1912 **Gesregen, Wm. E., M. D.,** Resident Physician Belle Mead Farm Colony and Sanatorium, Belle Mead, N. J.

1917 **Gibson, Edward T., M. D.,** Clinical Director Connecticut Hospital for Insane, Middletown, Conn. (*Associate.*)

1914 **Gibson, Horatio G., Jr., M. D.,** Assistant Physician Central Islip State Hospital, Central Islip, N. Y. (*Associate.*)

1909 **Gillespie, Edward, M. D.,** Senior Assistant Physician Binghamton State Hospital, Binghamton, N. Y. (*Associate.*)

1917 **Gillfillan, Donald R., M. D.,** Assistant Physician Worcester State Hospital, Worcester, Mass. (*Associate.*)

1915 **Gillis, Andrew C., M. D.,** 914 N. Charles St., Baltimore, Md.

1893 **Givens, A. J., M. D.,** Proprietor Dr. Givens' Sanitarium, Stamford, Conn.

1895 **Givens, John W., M. D.,** Medical Superintendent Northern Idaho Insane Asylum, Orofino, Idaho.

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1910 **Glascock, Alfred, M. D.,** Senior Assistant Physician St. Elizabeth Hospital, Washington, D. C. (*Associate.*)

1914 **Glueck, Bernard, M. D.,** P. O. Box 143, Ossining, N. Y. (*Associate.*)

1916 **Goff, A. P., M. D.,** Chief San Lazaro Hospital, Manilla, P. I.

1903 **Goodwill, V. L., M. D.,** and **C. M.,** 84 York St., Charlottetown, P. E. I.

1912 **Gordon, Alfred, M. D.,** 1812 Spruce St., Philadelphia, Pa.

1912 **Gorrill, George W., M. D.,** First Assistant Physician Buffalo State Hospital, Buffalo, N. Y. (*Associate.*)

1906 **Gorst, Charles, M. D.,** Mendota, Wis.

1915 **Gosline, Harold I., M. D.,** Assistant Physician New Jersey State Hospital, Trenton, N. J. (*Associate.*)

1898 **Goss, Arthur V., M. D.,** Superintendent Taunton State Hospital, Taunton, Mass.

1886 **Granger, Wm. D., M. D.,** Vernon House, Bronxville, N. Y.

1905 **Green, Edward M., M. D.,** Superintendent Harrisburg State Hospital, Harrisburg, Pa.

1909 **Greene, Edward C., M. D.,** Northampton State Hospital, Northampton, Mass. (*Associate.*)

1910 **Greene, James L., M. D.,** Hot Springs, Ark.

1916 **Greene, Ralph N., M. D.,** 438 St. James Bldg., Jacksonville, Fla.

1917 **Greenwood, James, M. D.,** President Dr. Greenwood's Sanitarium, Houston, Tex.

1914 **Gregg, Donald, M. D.,** Associate Physician Channing Sanitarium, Brookline, Mass.

1917 **Gregory, Hugh S., M. D.,** Assistant Physician St. Lawrence State Hospital, Ogdensburg, N. Y. (*Associate.*)

1908 **Gregory, Menas S., M. D.,** Resident Alienist Bellevue Hospital, New York, N. Y.

1913 **Griffin, D. W., M. D.,** Superintendent Oklahoma State Hospital, Norman, Okla.

1913 **Groom, Wirt C., M. D.,** Assistant Physician Willard State Hospital, Willard, N. Y. (*Associate.*)

1914 **Grover, Milton M., M. D.,** Kings Park State Hospital, Kings Park, N. Y. (*Associate.*)

1910 **Guibord, Alberta S. B., M. D.,** 512 Albany Building, Boston, Mass.

1900 **Gundry, Alfred T., M. D.,** Medical Director The Gundry Sanitarium, Catonsville, Md.

1908 **Gundry, Lewis H., M. D.,** Superintendent Relay Sanitarium, Relay, Baltimore Co., Md.

1892 **Gundry, Richard F., M. D.,** Medical Director and Proprietor the Richard Gundry Home, Harlem Lodge, Catonsville, Md.

1899 **Guthrie, L. V., M. D.,** Superintendent Huntington State Hospital, Huntington, W. Va.

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H

1914 **Haberman, J. Victor, M. D.,** Instructor in Neurology and Psychotherapy P. and S., Columbia University, New York, N. Y.

1917 **Hackett, John F., M. D.,** Assistant Physician Colony for Epileptics, Mansfield Depot, Conn. (*Associate.*)

1916 **Haines, Thomas H., M. D.,** Columbus, O.

1891 **Hall, G. Stanley, Ph. D., LL. D.,** President Clark University, Worcester, Mass. (*Honorary.*)

1886 **Hall, Henry C., M. D.,** Assistant Superintendent Butler Hospital, Providence, R. I. (*Associate.*)

1915 **Hall, Jas. K., M. D.,** Resident Physician Westbrook Sanatorium, Richmond, Va.

1916 **Halterman, Charles W., M. D.,** Clarksburg, W. Va.

1899 **Hamilton, Arthur S., M. D.,** Instructor in Nervous and Mental Diseases and Neuropathology, College of Medicine and Surgery, University of Minnesota, 513 Pillsbury Building, Minneapolis, Minn.

1907 **Hamilton, Gilbert V., M. D.,** Montecito, Cal.

1907 **Hamilton, Samuel W., M. D.,** Senior Assistant Physician Utica State Hospital, Utica, N. Y.

1912 **Hammers, James S., M. D.,** Assistant Physician State Hospital, Danville, Pa. (*Associate.*)

1917 **Hammes, Ernest M., M. D.,** Teacher Nervous and Mental Diseases University of Minnesota, St. Paul, Minn.

1908 **Hammond, Frederick S., M. D.,** Atlantic Highlands, N. J. (*Associate.*)

1908 **Hammond, Graeme M., M. D.,** Professor of Mental Diseases, 60 W. 56th St., New York, N. Y.

1893 **Hancker, W. H., M. D.,** Medical Superintendent Delaware State Hospital, Farnhurst, Del.

1906 **Hanes, Edward L., M. D.,** 748 Main St., E., Rochester, N. Y.

1913 **Hanson, Wm. T., M. D.,** Mass. State Infirmary, Tewksbury, Mass. (*Associate.*)

1904 **Harding, George T., Jr., M. D.** (Neurologist to Grant Hospital, St. Anthony's Hospital and St. Clair Hospital), 318 E. State St., Columbus, O.

1891 **Harmon, F. W., M. D.,** Medical Superintendent Longview Hospital, Cincinnati, O.

1918 **Harper, Mrs. Neil A.,** Gatun, Canal Zone.

1894 **Harrington, Arthur H., M. D.,** Superintendent State Hospital for Insane, Howard, R. I.

1917 **Harrington, John J., M. D.,** Clinical Director Osawatomie State Hospital, Osawatomie, Kans. (*Associate.*)

1913 **Harris, George F., M. D.,** 209 Vestal Ave., Binghamton, N. Y. (*Associate.*)

1899 **Harris, Isham G., M. D.,** Superintendent Brooklyn State Hospital, Brooklyn, N. Y.

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1888 **Harrison, Daniel A., M. D.,** Breezehurst Terrace, Whitestone, L. I., N. Y.

1915 **Haskell, Pearl T., M. D.,** Superintendent State Hospital, Bangor, Maine. (*Associate.*)

1915 **Haskell, Robt. Henry, M. D.,** Superintendent Ionia State Hospital, Ionia, Mich.

1913 **Hasking, Arthur P., M. D.,** Official Examiner of Indigent Insane, Hudson Co., 318 Montgomery St., Jersey City, N. J.

1914 **Hassall, James C., M. D.,** Assistant Physician St. Elizabeth Hospital, Washington, D. C. (*Associate.*)

1910 **Hatch, F. W., M. D.,** General Superintendent of California State Hospitals, Sacramento, Cal.

1913 **Hatcher, George E., M. D.,** Cerulean, Ky.

1894 **Hattie, W. H., M. D.,** Inspector of Humane and Penal Institutions, Halifax, N. S.

1899 **Haviland, C. Floyd, M. D.,** Superintendent State Hospital, Middletown, Conn.

1914 **Haviland, Walter C., M. D.,** 11 Elm St., Worcester, Mass.

1908 **Hawke, W. W., M. D.,** "The Eyrie," Clifton Heights, Delaware Co., Pa.

1915 **Hawkins, G. G., M. D.,** First Assistant Physician Eastern State Hospital, Williamsburg, Va. (*Associate.*)

1916 **Hawley, N. C., M. D.,** Assistant Superintendent Elgin State Hospital, Elgin, Ill. (*Associate.*)

1910 **Hedin, Carl J., M. D.,** Superintendent Maine School for Feeble-Minded, W. Pownal, Me.

1912 **Helmer, Ross D., M. D.,** Assistant Physician Hudson River State Hospital, Poughkeepsie, N. Y. (*Associate.*)

1915 **Henderson, David Kennedy, M. D.,** Resident Psychiatrist, Phipps Clinic, Johns Hopkins Hospital, Baltimore, Md. (*Associate.*) (Present address, Royal Asylum Gartnavel, Glasgow, Scotland.)

1913 **Henderson, Estelle H., M. D.,** Superintendent Southwestern State Hospital, Marion, Va.

1912 **Henry, Hugh Carter, M. D.,** First Assistant Physician Central State Hospital, Petersburg, Va. (*Associate.*)

1911 **Henschel, Louis K., M. D.,** M. R. C., U. S. Army. (*Associate.*)

1911 **Herring, Arthur P., M. D.,** Secretary State Lunacy Commission, 330 N. Charles St., Baltimore, Md.

1894 **Heyman, Marcus B., M. D.,** Superintendent Manhattan State Hospital, Wards Island, N. Y.

1911 **Hickling, D. Percy, M. D.,** Alienist of District of Columbia, 1304 Rhode Island Ave., N. W., Washington, D. C.

1916 **Hicks, H. E., M. D.,** Assistant Superintendent Brandon Asylum, Brandon, Manitoba. (*Associate.*)

1917 **Hill, Charles B., M. D.,** Superintendent Oklahoma Hospital for Insane, Supply, Okla.

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1883 **Hill, Chas. G., M. D.,** Physician-in-Chief Mt. Hope Retreat, Baltimore, Md. (*President, 1907.*)

1883 **Hill, Gershom H., M. D.,** Superintendent "The Retreat," Des Moines, Ia.

1916 **Hill, Ralph L., M. D.,** Superintendent Allegheny Hospital for Insane, Woodville, Pa.

1899 **Hill, S. S., M. D.,** Superintendent State Asylum for the Chronic Insane, Wernersville, Pa.

1897 **Hills, Frederick L., M. D.,** Pittsford, Vt.

1886 **Hinckley, L. S., M. D.** (formerly Medical Superintendent Essex County Hospital), 182 Clinton Ave., Newark, N. J.

1913 **Hinton, Ralph T., M. D.,** Superintendent Elgin State Hospital, Elgin, Ill.

1900 **Hirsch, Wm., M. D.,** Neurologist to the German Poliklinic, 52 E. 64th St., New York, N. Y.

1916 **Hiscock, Robt. C., M. D.,** Assistant Physician Protestant Hospital, Verdun, Que. (*Associate.*)

1900 **Hitchcock, Chas. W., M. D.,** Attending Neurologist Harper Hospital, 270 Woodward Ave., Detroit, Mich.

1903 **Hobbs, Alfred T., M. D.,** Superintendent Homewood Sanitarium, Guelph, Ont.

1895 **Hoch, August, M. D.,** Riven Rock, Santa Barbara, Cal.

1904 **Hoch, Theodore A., M. D.,** Assistant Physician McLean Hospital, Waverley, Mass. (*Associate.*)

1914 **Hodskin, Morgan B., M. D.,** Assistant Physician Monson State Hospital, Palmer, Mass. (*Associate.*)

1914 **Hoffman, Harry F., M. D.,** Assistant Superintendent Homeopathic State Hospital, Allentown, Pa. (*Associate.*)

1917 **Hoisholt, Andrew W., M. D.,** Superintendent Napa State Hospital, Napa, Cal.

1915 **Holbrook, Chas. S., M. D.,** Assistant Physician Eastern La. Hospital for the Insane, Jackson, La. (*Associate.*)

1900 **Holley, Erving, M. D.,** Assistant Physician Long Island State Hospital, Brooklyn, N. Y. (*Associate.*)

1915 **Holt, Earl K., M. D.,** Assistant Physician Hospital for the Insane, Logansport, Ind. (*Associate.*)

1916 **Horger, E. L., M. D.,** Pathologist State Hospital, Columbia, S. C. (*Associate.*)

1913 **Horsman, Hiram L., M. D.,** Assistant Physician Grafton State Hospital, Worcester, Mass. (*Associate.*)

1913 **Hotchkiss, W. M., M. D.,** Superintendent State Hospital for Insane, Jamestown, N. Dak.

1894 **Houston, John A., M. D.,** Medical Superintendent Northampton State Hospital, Northampton, Mass.

1894 **Howard, A. B., M. D.** (formerly Medical Superintendent Cleveland State Hospital), 736 Rose Building, Cleveland, Ohio.

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1888 **Howard, Eugene H., M. D.,** Medical Superintendent Rochester State Hospital, Rochester, N. Y.

1894 **Howard, Herbert B., M. D.,** Superintendent Peter Bent Brigham Hospital, 697 Huntington Ave., Boston, Mass.

1912 **Hubbard, O. S., M. D.,** Superintendent Kansas State Hospital for Epileptics, Parsons, Kans. (*Associate.*)

1907 **Hummer, Henry R., M. D.,** Superintendent Asylum for Insane Indians, Canton, S. Dak.

1899 **Hun, Henry, M. D.,** Albany, N. Y. (*Honorary.*)

1916 **Hunnicutt, Wm. P., M. D.,** Assistant Physician Colorado Insane Asylum, Pueblo, Colo. (*Associate.*)

1894 **Hurd, Arthur W., M. D.,** Medical Superintendent Buffalo State Hospital, Buffalo, N. Y.

1879 **Hurd, Henry M., M. D.,** Secretary Johns Hopkins Hospital, 1023 St. Paul St., Baltimore, Md. (*President, 1899.*)

1897 **Hutchings, Richard H., M. D.,** Medical Superintendent St. Lawrence State Hospital, Ogdensburg, N. Y.

1899 **Hutchinson, Anna E., M. D.,** Woman Assistant Physician Manhattan State Hospital, Ward's Island, New York, N. Y. (*Associate.*)

1885 **Hutchinson, Henry A., M. D.,** Medical Superintendent The Dixmont Hospital for the Insane, Dixmont, Pa.

1917 **Hyde, Arthur G., M. D.,** Superintendent Cleveland State Hospital, Cleveland, O.

1916 **Hyde, Geo. E., M. D.,** Medical Superintendent Utah State Mental Hospital, Provo, Utah.

I

1901 **Inch, Geo. Franklin, M. D.,** Assistant Medical Superintendent Kalamazoo State Hospital, Kalamazoo, Mich. (*Associate.*)

1913 **Ingram, Robert, M. D.,** Neurologist Cincinnati Hospital, Cincinnati, O.

1912 **Isham, Mary Keyt, M. D.,** 135 W. 79th St., New York, N. Y.

J

1913 **Jackson, J. Allen, M. D.,** Chief Resident Physician Philadelphia Hospital for Insane, Philadelphia, Pa.

1912 **Jacobs, Wilma H., M. D.,** Jacksonville State Hospital, Jacksonville, Ill. (*Associate.*)

1913 **Jacoby, J. Ralph, M. D.,** 54 W. 88th St., New York, N. Y.

1916 **James, C. E., M. D.,** Massillon State Hospital, Massillon, O. (*Associate.*)

1908 **Jelliffe, Smith Ely, M. D.,** Visiting Neurologist City Hospital, 64 W. 56th St., New York, N. Y.

1903 **Jelly, Arthur C., M. D.,** 10 Arlington St., Boston, Mass.

1917 **Jewett, Stephen P., M. D.,** Assistant Physician River Crest Sanitarium, New York, N. Y. (*Associate.*)

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1915 **Jones, Kenneth B., M. D.**, Rosewood State Training School, Owings Mills, Md.

1909 **Jones, L. M., M. D.**, Superintendent Georgia State Sanitarium, Milledgeville, Ga.

1915 **Jones, Wm. A., M. D.**, Pillsbury Bldg., Minneapolis, Minn.

1909 **Jordan, M. M., M. D.**, Assistant Physician Westborough State Hospital, Westborough, Mass. (*Associate.*)

K

1906 **Karpas, Morris J., M. D.**, Psychopathic Pavilion, Bellevue Hospital, New York, N. Y. (*Associate.*)

1915 **Keating, Frank W., M. D.**, Superintendent Rosewood School for Feeble-Minded, Owings Mills, Md.

1914 **Keatley, Harry W., M. D.**, M. R. C., U. S. Army. (*Associate.*)

1917 **Kehoe, H. C., M. D.**, Ft. Myers, Fla.

1872 **Kellogg, Theo. H., M. D.**, Riverdale Lane and Albany Post Road, Riverdale, New York, N. Y.

1913 **Kelly, Wm. E., M. D.**, Assistant Physician Middletown State Homeopathic Hospital, Middletown, N. Y. (*Associate.*)

1914 **Kempf, Edward J., M. D.**, Clinical Psychiatrist St. Elizabeth Hospital, Washington, D. C. (*Associate.*)

1915 **Kempf, Grover A., M. D.**, Assistant Surgeon United States Public Health Service, Ellis Island, N. Y.

1890 **Keniston, J. M., M. D.**, 208 Eastern Promenade, Portland, Me. (*Associate.*)

1915 **Kenworthy, Marion E., M. D.**, Assistant Physician Foxborough State Hospital, Foxborough, Mass. (*Associate.*)

1912 **Kern, W. B., M. D.**, Medical Superintendent Norwalk State Hospital, Norwalk, Cal.

1910 **Kieb, Raymond F. C., M. D.**, Superintendent Matteawan State Hospital, Beacon, N. Y.

1890 **Kilbourne, Arthur F., M. D.**, Medical Superintendent Rochester State Hospital, Rochester, Minn. (*President, 1909.*)

1895 **Kindred, J. J., M. D.**, Proprietor and Consulting Physician of the River Crest Sanitarium, Astoria, L. I., N. Y.

1913 **Kineon, G. G., M. D.**, Superintendent Ohio Hospital for Epileptics, Gallipolis, O.

1917 **King, Cheston, M. D.**, Cheston King Sanitarium, Atlanta, Ga.

1912 **King, Florence A., M. D.**, Hudson River State Hospital, Poughkeepsie, N. Y. (*Associate.*)

1908 **King, George W., M. D.**, Medical Director Hudson County Hospital for Insane, Secaucus, N. J.

1910 **King, John C., M. D.**, St. Albans Sanitarium, Radford, Va.

1912 **King, Robert, M. D.**, Assistant Physician Buffalo State Hospital, Buffalo, N. Y. (*Associate.*)

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1914 **Kingsley, Alfred C., M. D.,** Superintendent Arizona State Hospital, Phoenix, Ariz.

1901 **Kinney, C. Spencer, M. D.,** Proprietor Easton Sanitarium, Easton, Pa.

1910 **Kirby, George H., M. D.,** Director Psychiatric Institute, Ward's Island, New York, N. Y.

1905 **Kline, George M., M. D.,** Director Massachusetts Commission on Mental Diseases, State House, Boston, Mass.

1900 **Klopp, Henry L., M. D.,** Superintendent Homeopathic State Hospital, Allentown, Pa.

1899 **Knapp, John Rudolph, M. D.,** Assistant Physician Manhattan State Hospital, Ward's Island, New York, N. Y. (*Associate.*)

1913 **Knight, Arthur Clyde, M. D.,** 301 Phoenix Block, Butte, Mont.

1902 **Kuhlman, Helene J. C., M. D.,** Assistant Physician Buffalo State Hospital, Buffalo, N. Y. (*Associate.*)

L

1901 **Lamb, Robert B., M. D.,** Craig House, Beacon-on-Hudson, N. Y.

1917 **Lambert, Charles I., M. D.,** Assistant Physician Bloomingdale Hospital, White Plains, N. Y. (*Associate.*)

1900 **La Moure, Chas. T., M. D.,** Superintendent Mansfield State Training School and Hospital, Mansfield Depot, Conn.

1911 **La Moure, Howard A., M. D.,** Superintendent Colorado State Insane Asylum, Pueblo, Col.

1908 **Landers, George B., M. D.,** Superintendent Morristown Memorial Hospital, Morristown, N. J. (*Associate.*)

1912 **Lane, Arthur G., M. D.,** Assistant Physician St. Lawrence State Hospital, Ogdensburg, N. Y. (*Associate.*)

1892 **Lane, Edward B., M. D.,** Resident Physician Adams Nervine Asylum, 419 Boylston St., Boston, Mass.

1913 **Lang, Walter E., M. D.,** Senior Assistant Physician Homeopathic State Hospital, Allentown, Pa. (*Associate.*)

1903 **Langdon, F. W., M. D.,** Medical Director Cincinnati Sanitarium; Professor of Psychiatry, University of Cincinnati, 4003 Rose Hill Ave., Cincinnati, Ohio.

1906 **Laughlin, Charles E., M. D.,** Superintendent Southern Indiana Hospital for the Insane, Evansville, Ind.

1907 **Lawlor, Fred E., M. D.,** Superintendent Nova Scotia Hospital, Halifax, N. S.

1882 **Lawton, Shailer E., M. D.,** Medical Superintendent Brattleboro Retreat, Brattleboro, Vt.

1911 **Leader, Pauline M., M. D.,** Woman Physician Clarinda State Hospital, Clarinda, Iowa. (*Associate.*)

1912 **Leahy, Sylvester R., M. D.,** Resident Alienist Kings Co. Hospital, Brooklyn, N. Y.

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1901 **Leak, Roy L., M. D.,** Medical Director State Hospital, Columbia, S. C.
1912 **Leavitt, William, M. D.,** Assistant Physician Central Islip State Hospital, Central Islip, N. Y. (*Associate.*)
1914 **Lee, Herbert, M. D.,** Resident Physician Dr. Woodson's Sanitarium, St. Joseph, Mo.
1914 **Leehman, Helene G., M. D.,** Assistant Physician Essex County Hospital, Cedar Grove, N. J. (*Associate.*)
1917 **Leonard, Christine, M. D.,** Assistant Physician Municipal Courts, Boston, Mass. (*Associate.*)
1913 **Leonard, Edward F., M. D.,** 3501 N. Hermitage Ave., Chicago. Ill.
1913 **Levin, Hyman L., M. D.,** Assistant Physician St. Lawrence State Hospital, Ogdensburg, N. Y. (*Associate.*)
1900 **Lewis, J. M., M. D.** (formerly Superintendent Cleveland State Hospital), 436 Rose Bldg., Cleveland, Ohio.
1914 **Lind, John E., M. D.,** Senior Assistant Physician St. Elizabeth Hospital, Washington, D. C. (*Associate.*)
1910 **Lindsay, S. C., M. D.,** Capt. M. R. C., U. S. Army. (*Associate.*)
1917 **Lindsay, William S., M. D.,** Christ's Hospital Cottages, Topeka, Kans.
1915 **Llewellyn, G. S., M. D.,** First Assistant Physician Pittsburgh City Home, Marshalsea, Boyce, Pa. (*Associate.*)
1915 **Locke, Hersey G., M. D.,** Physician-in-Charge Genesee Sanitarium, Syracuse, N. Y.
1899 **Logie, Benjamin Rush, M. D.,** 1836 Connecticut Ave., Washington, D. C.
1909 **Long, T. L., M. D.,** State Colony for Epileptics, Woodward, Ia.
1911 **Lorenz, William F., M. D.,** First Assistant Physician Wisconsin State Hospital for Insane, Mendota, Wis. (*Associate.*)
1909 **Love, George R., M. D.,** Superintendent Toledo State Hospital, Toledo, Ohio.
1913 **Lowe, Charles R., M. D.,** Lincoln State School and Colony, Lincoln, Ill. (*Associate.*)
1903 **Ludlum, Seymour DeWitt, M. D.,** Merion, Pa. (*Associate.*)
1912 **Lustig, Daniel D., M. D.,** 146 Grant Ave., San Francisco, Cal.
1913 **Lyon, Charles G., M. D.,** Superintendent Dr. Lyon's Sanitarium, Binghamton, N. Y.
1882 **Lyon, Samuel B., M. D.,** The Mansfield, 12 W. 44th St., N. Y.

M

1894 **McBride, James H., M. D.,** 489 Bellefontaine St., Pasadena, Cal.
1909 **McCafferty, Emit L., M. D.,** Assistant Superintendent Mt. Vernon Hospital, Mt. Vernon, Ala.
1910 **McCampbell, John, M. D.,** Superintendent State Hospital, Morganton, N. C.
1909 **McCarthy, D. J., M. D.,** Professor of Medical Jurisprudence University of Pennsylvania and Woman's Medical College, Philadelphia, Pa.

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1916 **McCloud, J. J., M. D.,** Assistant Physician Institution for Feeble-Minded, Columbus, O. (*Associate.*)

1917 **McDaniel, Fred L., M. D.,** Assistant Physician Osawatomie State Hospital, Osawatomie, Kans. (*Associate.*)

1903 **McDonald, William, Jr., M. D.,** 188 Blackstone Boulevard, Providence, R. I.

1915 **McFadden, Jas. F., M. D.,** Officers Club Jefferson Barracks, Mo. (*Associate.*)

1909 **McGaffin, Charles Gibson, M. D.,** Pathologist and Assistant Physician Kings Park State Hospital, Kings Park, N. Y.

1911 **McKay, James G., M. D.,** Assistant Physician Hospital for Insane, New Westminster, B. C.

1905 **McKelway, John Irvine, M. D.,** Second Assistant Superintendent Eastern Oregon State Hospital, Pendleton, Ore.

1907 **McKinniss, Clyde R., M. D.,** Superintendent Pittsburgh City Hospital, Boyce Station, Pa.

1917 **McPherson, George E., M. D.,** Assistant Superintendent Medfield State Hospital, Medfield, Mass. (*Associate.*)

1915 **MacCurdy, John T., M. D.,** Assistant Physician Psychiatric Institute, New York City.

1874 **MacDonald, Carlos F., M. D.,** 15 E. 48th St., New York, N. Y. (*President, 1914.*)

1914 **Macdonald, John B., M. D.,** Superintendent Danvers State Hospital, Hathorne, Mass.

1915 **MacDonald, Thos. D., M. D.,** Assistant Physician Dr. MacDonald's House, Central Valley, N. Y. (*Associate.*)

1917 **MacIntyre, Wm. A., M. D.,** Assistant Physician Grafton State Hospital, North Grafton, Mass. (*Associate.*)

1915 **MacIver, Geo. A., M. D.,** Assistant Resident Physician Massachusetts General Hospital, Boston, Mass. (*Associate.*)

1913 **Mack, Clifford W., M. D.,** Livermore Sanitarium, Livermore, Cal.

1907 **Mackin, M. Charles, M. D.,** Superintendent State Hospital for Inebriates, Knoxville, Ia.

1906 **Mackintosh, J. A., M. D.,** Quantico, Md.

1912 **MacNaughton, Peter, M. D.,** Assistant Superintendent Hospital for Insane, Hamilton, Ont. (*Associate.*)

1916 **MacNiell, James W., M. D.,** Superintendent Provincial Hospital, Battleford, Saskatchewan.

1917 **MacPhee, Catherine, M. D.,** Assistant Physician Psychopathic Hospital, Boston, Mass. (*Associate.*)

1897 **Macy, Wm. Austin, M. D.,** Kings Park, L. I., N. Y.

1912 **Malberti, José A., M. D.,** Malberti's Sanitarium, Havana, Cuba.

1900 **Manton, Walter P., M. D.,** Gynecologist Eastern and Northern Michigan Asylums; Consulting Gynecologist St. Joseph's Retreat, 32 Adams Ave., West, Detroit. Mich.

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1915 **Markham, Convas L., M. D.,** Superintendent Brunswick Home, Amityville, N. Y.

1915 **Mason, B. Henry, M. D.,** First Assistant Physician Worcester State Hospital, Worcester, Mass. (*Associate.*)

1911 **Matthews, Adelbert C., M. D.,** First Assistant Physician Napa State Hospital, Napa, Cal.

1912 **Matzinger, Herman G., M. D.,** 90 Soldier's Place, Buffalo, N. Y.

1904 **Maxfield, Geo. H., M. D.,** Soldiers' Home, Chelsea, Mass. (*Associate.*)

1912 **May, Herman F., M. D.,** Assistant Physician Buffalo State Hospital, Buffalo, N. Y. (*Associate.*)

1910 **May, James V., M. D.,** Superintendent Boston State Hospital, Dorchester Center, Mass.

1894 **Mayberry, Chas. B., M. D.,** Superintendent Hospital for the Insane of the Central Poor District of Luzerne County, Retreat, Luzerne Co., Pa.

1902 **Mayer, Edward E., M. D.,** Clinical Professor of Neurology University of Pittsburgh, Keenan Bldg., Pittsburgh, Pa.

1893 **Mead, Leonard C., M. D.,** Medical Superintendent South Dakota Hospital for the Insane, Yankton, S. D.

1917 **Means, P. B., M. D.,** Assistant Physician New Jersey State Hospital, Trenton, N. J. (*Associate.*)

1912 **Mellus, Edward, M. D.,** Superintendent Dr. Mellus' Private Hospital, 419 Waverley Ave., Newton, Mass.

1891 **Meredith, Hugh B., M. D.,** Medical Superintendent State Hospital for the Insane, Danville, Pa.

1912 **Merriman, Willis E., M. D.,** Assistant Physician Hudson River State Hospital, Poughkeepsie, N. Y. (*Associate.*)

1893 **Meyer, Adolf, M. D.,** Professor of Psychiatry Johns Hopkins University, 101 Edgevale Road, Roland Park, Md.

1914 **Mikels, Frank M., M. D.,** 631 1st National Bank Bldg., Long Beach, Cal. (*Associate.*)

1915 **Miller, F. B. E., M. D.,** Assistant Physician State Hospital for the Insane, Cherokee, Iowa. (*Associate.*)

1904 **Miller, Henry W., M. D.,** "Mountainbrook," Brewster, N. Y.

1917 **Miller, S. Metz, M. D.,** Chief Resident Physician State Hospital, Norristown, Pa.

1916 **Milligan, James W., M. D.,** Medical Superintendent Southeastern Hospital, Madison, Ind.

1893 **Mills, Chas. K., M. D.,** Professor of Neurology University of Pennsylvania, 1909 Chestnut St., Philadelphia, Pa.

1915 **Mills, Harlan P., M. D.,** First Assistant Physician Arizona State Hospital, Phoenix, Ariz. (*Associate.*)

1907 **Millspaugh, Daniel T., M. D.,** Superintendent "Riverlawn," 47 Totowa Ave., Paterson, N. J.

1899 **Mitchell, H. W., M. D.,** Superintendent Warren State Hospital, Warren, Pa.

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1912 **Mitchell, John C., M. D.,** Superintendent Hospital for the Insane, Brockville, Ont.

1908 **Mitchell, Roy E., M. D.,** Boberg Building, Eau Claire, Wis.

1903 **Montgomery, Wm. H., M. D.,** Senior Assistant Physician Willard State Hospital, Willard, N. Y. (*Associate.*)

1916 **Moody, T. L., M. D.,** Resident Physician Dr. Moody's Sanitarium, San Antonio, Tex. (*Associate.*)

1912 **Moore, Arthur S., M. D.,** Assistant Physician Middletown State Hospital, Middletown, N. Y. M. R. C., U. S. Army. (*Associate.*)

1914 **Moore, Joseph W., M. D.,** First Assistant Physician Matteawan State Hospital, Beacon, N. Y. (*Associate.*)

1896 **Morel, Jules, M. D.,** Medical Superintendent State Asylum; Commissioner in Lunacy, 56 Boulevard Leopold, Ghent, Belgium. (*Honorary.*)

1913 **Morris, John N., M. D.,** Springfield State Hospital, Sykesville, Md. (*Associate.*)

1917 **Morrison, Angus W., M. D.,** 406 P. & S., Minneapolis, Minn.

1913 **Morse, Mary E., M. D.,** Boston State Hospital, Dorchester Center, Boston, Mass. (*Associate.*)

1893 **Mosher, J. Montgomery, M. D.,** 170 Washington Ave., Albany, N. Y.

1881 **Motet, A. M., M. D.,** 161 Rue de Charonne, Paris, France. (*Honorary.*)

1915 **Mullan, E. H., M. D.,** Ellis Island, N. Y.

1916 **Munnerlyn, J. F., M. D.,** Assistant Physician Hospital for Insane, Columbia, S. C. (*Associate.*)

1886 **Munson, James D., M. D.,** Medical Superintendent Northern Michigan Asylum, Traverse City, Mich.

1907 **Munson, James F., M. D.,** Resident Pathologist Craig Colony for Epileptics, Sonyea, N. Y.

1909 **Murdock, J. Morehead, M. D.,** Superintendent State Institution Feeble-Minded of Western Pennsylvania, Polk, Pa.

1914 **Murphy, Wm. A., M. D.,** 44 W. 44th St., New York, N. Y. (*Associate.*)

1912 **Myers, Glenn E., M. D.,** Agnew State Hospital, Agnew, Cal. (*Associate.*)

N

1914 **Nairn, B. Ross, M. D.,** 281 Park Side Ave., Buffalo, N. Y.

1896 **Neff, Irwin H., M. D.,** Superintendent Norfolk State Hospital, Pondville, Mass.

1913 **Neff, Mary Lawson, M. D.,** Phoenix, Ariz.

1914 **Neuhaus, George E., M. D.,** Superintendent Mt. Airy Sanatorium, Denver, Col.

1916 **Neuman, Theodor W., M. D.,** Assistant Physician Hudson River State Hospital, Poughkeepsie, N. Y. (*Associate.*)

1905 **Nevin, Ethan A., M. D.,** Superintendent Custodial Asylum, Newark, N. Y.

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1913 **Nevitt, C. A., M. D.**, Superintendent Elmwood Sanitarium, Lexington, Ky.

1915 **Newcomb, Philip B., M. D.**, Pathologist Mt. Pleasant State Hospital, Mt. Pleasant, Ia. (*Associate.*)

1900 **Nichols, John H., M. D.**, Resident Physician and Superintendent State Infirmary, Tewksbury, Mass.

1913 **Nickerson, Mary A., M. D.**, Rochester State Hospital, Rochester, N. Y. (*Associate.*)

1886 **Nims, Edward B., M. D.** (formerly Superintendent Northampton Insane Hospital), 40 Harvard St., Springfield, Mass.

1912 **Noble, Ermy C., M. D.**, Assistant Superintendent Boston State Hospital, Dorchester Center, Mass. (*Associate.*)

1912 **Noble, Mary E. Gill, M. D.**, Assistant Physician Boston State Hospital, Dorchester Centre, Mass. (*Associate.*)

1903 **Norbury, Frank P., M. D.**, Medical Director, The Norbury Sanatorium, Jacksonville, Ill.

1912 **Norquay, H. C., M. D.**, Assistant Superintendent Selkirk Hospital for Insane, Selkirk, Manitoba, Canada. (*Associate.*)

1917 **Norris, Lester F., M. D.**, Assistant Physician Bangor State Hospital, Bangor, Me. (*Associate.*)

1914 **North, Emerson A., M. D.**, Resident Physician Cincinnati Sanitarium, Cincinnati, O. (*Associate.*)

O

1904 **O'Brien, John D., M. D.**, Capt. M. R. C., U. S. Army.

1913 **O'Brien, John F., M. D.**, Taunton State Hospital, Taunton, Mass. (*Associate.*)

1905 **O'Hanlon, George, M. D.**, Bellevue Hospital, New York, N. Y.

1917 **O'Hara, Joseph A., M. D.**, Orleans Hospital for Mental Diseases, New Orleans, La.

1912 **O'Harrow, Marian, M. D.**, Assistant Physician Friends' Hospital, Frankford, P. O. Box 20, Station F, Philadelphia, Pa. (*Associate.*)

1908 **O'Malley, Mary, M. D.**, Senior Assistant Physician St. Elizabeth Hospital, Washington, D. C. (*Associate.*)

1916 **O'Meara, Michael J., M. D.**, Assistant Physician Grafton State Hospital, Worcester, Mass.

1889 **Orth, H. L., M. D.**, Harrisburg, Pa.

1907 **Orton, Samuel T., M. D.**, Clinical Director and Pathologist Pennsylvania Hospital, Department for Mental and Nervous Diseases, West Philadelphia, Pa.

1915 **Osnato, Michael, M. D.**, 270 W. 89th St., New York, N. Y.

1898 **Ostrander, Herman, M. D.**, Medical Superintendent Kalamazoo State Hospital, Kalamazoo, Mich.

1915 **Ostheimer, Alfred J.**, 2025 Walnut St., Philadelphia, Pa.

1917 **Otis, Walter J., M. D.**, Assistant Physician McLean Hospital, Waverley, Mass. (*Associate.*)

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P

1916 **Pace, Wm. J., M. D.,** Assistant Physician State Hospital, Columbia, S. C. (*Associate.*)

1907 **Packard, Frederick H., M. D.,** First Assistant Physician McLean Hospital, Waverley, Mass. (*Associate.*)

1904 **Packer, Flavius, M. D.,** Physician-in-Charge, West Hill, 261st St. and Broadway, New York, N. Y.

1889 **Page, Charles W., M. D.,** 94 Woodland St., Hartford, Conn.

1894 **Page, H. W., M. D.,** Superintendent Hospital Cottages for Children, Baldwinville, Mass.

1912 **Paine, Harlan L., M. D.,** Assistant Superintendent Gardner State Colony, Gardner, Mass. (*Associate.*)

1887 **Paine, N. Emmons, M. D.** (formerly Superintendent Westborough State Hospital), The Newton Sanatorium, West Newton, Mass.

1914 **Palmer, E., M. D.,** Assistant Physician Northern Hospital for Insane, Logansport, Ind. (*Associate.*)

1897 **Palmer, Harold L., M. D.,** Superintendent Utica State Hospital, Utica, N. Y.

1894 **Parant, A. Victor, M. D.,** Toulouse, France. (*Honorary.*)

1912 **Parker, Charles S., M. D.,** Assistant Physician Kings Park State Hospital, Kings Park, N. Y. (*Associate.*)

1913 **Parker, George M., M. D.,** St. Vincent's Hospital, New York, N. Y.

1905 **Parsons, Frederick W., M. D.,** First Assistant Physician Hudson River State Hospital, Poughkeepsie, N. Y. (*Associate.*)

1909 **Partlow, William D., M. D.,** Assistant Superintendent The Bryce Hospital, Tuscaloosa, Ala.

1913 **Patterson, Christopher J., M. D.,** Physician-in-Charge Marshall Sanitarium, Troy, N. Y.

1917 **Pattrell, Arthur E., M. D.,** Senior Assistant Physician Grafton State Hospital, North Grafton, Mass. (*Associate.*)

1912 **Payne, Guy, M. D.,** Medical Superintendent Essex Co. Hospital for Insane, Cedar Grove, N. J.

1897 **Pease, Caroline S., M. D.,** Assistant Physician St. Lawrence State Hospital, Ogdensburg, N. Y. (*Associate.*)

1916 **Pease, Edmund M., M. D.,** Assistant Physician Boston State Hospital, Dorchester Center, Mass. (*Associate.*)

1917 **Peddicord, F. L., M. D.,** Superintendent Central State Hospital, Lakeland, Ky.

1901 **Perry, Middleton L., M. D.,** Superintendent Topeka State Hospital, Topeka, Kans.

1893 **Peterson, Frederick, M. D.,** Professor of Psychiatry Columbia University, 20 W. 50th St., New York, N. Y.

1912 **Peterson, Jessie M., M. D.,** Resident Physician Department for Women, State Hospital, Norristown, Pa.

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1913 **Petery, Arthur K., M. D.,** First Assistant Physician State Hospital for the Insane, Norristown, Pa. (*Associate.*)

1912 **Pettijohn, Abra C., M. D.,** Room 24, Masonic Temple, Brookfield, Mo.

1914 **Pfeiffer, J. A. F., M. D.,** Senior Assistant Physician St. Elizabeth Hospital, Washington, D. C. (*Associate.*)

1913 **Phelps, R. M., M. D.,** Superintendent St. Peter State Hospital, St. Peter, Minn.

1910 **Pierson, Clarence, M. D.,** Superintendent East Louisiana Hospital for Insane, Jackson, La.

1914 **Pierson, Helena B., M. D.,** Assistant Physician Kings Park State Hospital, Kings Park, N. Y. (*Associate.*)

1913 **Pierson, Sarah G., M. D.,** Rochester State Hospital, Rochester, N. Y. (*Associate.*)

1913 **Pietrowicz, Stephen R., M. D.,** 1152 N. Ashland Ave., Chicago, Ill.

1890 **Pilgrim, Chas. W., M. D.,** Chairman State Hospital Commission, Albany, N. Y. (*President, 1911.*)

1910 **Pitman, Mason W. H., M. D.,** Riverdale-on-Hudson, New York, N. Y.

1914 **Poate, Ernest M., M. D.,** Senior Assistant Physician Manhattan State Hospital, Ward's Island, New York. (*Associate.*)

1914 **Podall, H. C., M. D.,** Assistant Physician State Hospital, Norristown, Pa.

1912 **Pogue, Mary E., M. D.,** Wheaton, Ill.

1910 **Pollock, Henry M., M. D.,** Superintendent Massachusetts Homeopathic Hospital, Boston, Mass.

1905 **Porteous, Carlyle A., M. D.,** Assistant Superintendent Protestant Hospital for the Insane, New P. O. Box 2280, Special Bag, Montreal, Canada.

1911 **Porter, William C., M. D.,** Assistant Physician Hudson River State Hospital, Poughkeepsie, N. Y. (*Associate.*)

1912 **Potter, Clarence A., M. D.,** Medical Superintendent Gowanda State Hospital, Collins, N. Y. (*Associate.*)

1913 **Potter, Frederick C., M. D.,** Pathologist Central Indiana Hospital for Insane, Indianapolis, Ind. (*Associate.*)

1913 **Powers, Herbert Wm., M. D.,** Milwaukee Sanitarium, Wauwatosa, Wis.

1906 **Preston, John, M. D.,** Superintendent State Lunatic Asylum, Austin, Tex.

1915 **Price, Susan A., M. D.,** Assistant Physician Eastern State Hospital, Williamsburg, Va.

1908 **Priddy, A. S., M. D.,** Superintendent Virginia State Epileptic Colony, Madison Heights, Va

1913 **Priestman, Gordon, M. D.,** Assistant Physician, Willard State Hospital, Willard, N. Y. (*Associate.*)

1917 **Pringle, Cyrus E., M. D.,** Assistant Physician Buffalo State Hospital, Buffalo, N. Y. (*Associate.*)

1914 **Pritchard, John A., M. D.,** Senior Assistant Physician St. Lawrence State Hospital, Ogdensburg, N. Y. (*Associate.*)

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1913 **Pritchard, William B., M. D.**, New York City Hospital, Blackwell's Island, New York, N. Y.

1908 **Pritchard, William H., M. D.**, Superintendent State Hospital, Columbus, O.

1898 **Prout, Thos. P., M. D.**, Fair Oaks Sanitarium, Summit, N. J.

1912 **Purdum, Harry D., M. D.**, Assistant Physician Springfield State Hospital, Sykesville, Md. (*Associate.*)

1898 **Putnam, Emma, M. D.**, Poughkeepsie, N. Y.

Q

1879 **Quinby, Hosea M., M. D.** (formerly Medical Superintendent Worcester State Hospital), Worcester, Mass.

1916 **Quinn, F. W., M. D.**, Assistant Physician Louisiana Hospital for Insane, Pineville, La. (*Associate.*)

R

1910 **Ramsey, William E., M. D.**, Perth Amboy, N. J.

1909 **Randolph, James H., M. D.**, St. James Building, Jacksonville, Fla.

1917 **Ranner, Dan S., M. D.**, Assistant Physician Village for Epileptics, Skillman, N. J. (*Associate.*)

1894 **Ratliff, J. M., M. D.**, Medical Superintendent Grandview Sanitarium, Price Hill, Cincinnati, O.

1913 **Ratliff, Thomas A., M. D.**, Grandview Sanitarium, Price Hill, Cincinnati, O.

1909 **Raynor, Mortimer W., M. D.**, Senior Assistant Physician Hudson River State Hospital, Poughkeepsie, N. Y. (*Associate.*)

1912 **Read, Charles F., M. D.**, Superintendent Chicago State Hospital, Dunning, Ill.

1913 **Reed, Ralph G., M. D.**, Assistant Physician State Hospital, Central Islip, N. Y.

1917 **Reeves, Harriet E., M. D.**, Superintendent Dr. Reeves Nervine, Melrose, Mass.

1896 **Régis, Emmanuel, M. D.**, Bordeaux, France. (*Honorary.*)

1916 **Register, D. W., M. D.**, Assistant Physician State Hospital, Columbia, S. C. M. R. C., U. S. Army. (*Associate.*)

1914 **Reid, Eva C., M. D.**, After-Care Physician California State Hospitals, University of California Hospital, San Francisco, Cal. (*Associate.*)

1914 **Reily, John A., M. D.**, Superintendent Southern California State Hospital, Patton, Cal.

1915 **Reitz, C. B., M. D.**, Pathologist Homeopathic State Hospital, Allentown, Pa. (*Associate.*)

1911 **Rhein, John H. W., M. D.**, Professor Diseases of Mind and Nervous System, Philadelphia Polyclinic and College of Medicine, 1732 Pine St., Philadelphia, Pa.

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1916 **Riach, Thomas J., M. D.,** Assistant Physician Kankakee State Hospital, Kankakee, Ill. M. R. C., U. S. Army.

1912 **Richards, Cyril G., M. D.,** Assistant Physician Long Island Hospital, Boston Harbor, Mass. (*Associate.*)

1911 **Richards, Robert L., M. D.,** Superintendent Mendocino State Hospital, Talmage, Cal.

1904 **Richardson, Wm. W., M. D.,** Medical Director The Mercer Sanitarium, Mercer, Pa. Capt. M. R. C., U. S. Army.

1908 **Ricksher, Charles, M. D.,** Ft. Sheridan, Ill. U. S. Army.

1913 **Ridgway, R. F. L., M. D.,** First Assistant Physician Pennsylvania State Lunatic Hospital, Harrisburg, Pa. (*Associate.*)

1902 **Riggs, Charles Eugene, M. D.,** Professor of Nervous and Mental Diseases and Chief of Department Neurology and Psychiatry, University of Minnesota, 10 Crocus Hill, St. Paul, Minn.

1911 **Riggs, George Henry, M. D.,** Superintendent Riggs Cottage-Sanitarium, Ijamsville, Md.

1917 **Rinde, Hamilton, M. D.,** Assistant Physician Connecticut Hospital for Insane, Middletown, Conn. (*Associate.*)

1910 **Ripley, Horace G., M. D.,** Assistant Superintendent State Hospital, Taunton, Mass.

1916 **Ritchey, R. M., M. D.,** Physician Elgin State Hospital, Elgin, Ill. M. R. C., U. S. Army. (*Associate.*)

1899 **Ritti, Antoine, M. D.,** Honorary Physician-in-Chief Maison Nationale de Charenton, 68 Boulevard Exelmans, Paris, France. (*Honorary.*)

1901 **Robertson, Frank W., M. D.** (formerly General Superintendent New York State Reformatory at Elmira), 422 West End Ave., New York.

1911 **Robinson, G. Wilse, M. D.,** Superintendent The Punton Sanitarium, Kansas City, Mo.

1913 **Robinson, Hedley V., M. D.,** Assistant Physician Protestant Hospital for the Insane, New P. O. Box 2280, Montreal, Que. (*Associate.*)

1917 **Robinson, Leigh F., M. D.,** Assistant Physician State Hospital, Raleigh, N. C. (*Associate.*)

1909 **Robinson, W. J., M. D.,** Superintendent Asylum for the Insane, London, Ontario.

1912 **Rogers, Arthur W., M. D.,** Superintendent Oconomawoc Health Resort for Nervous and Mental Diseases, Oconomawoc, Wis.

1907 **Rogers, Chas. B., M. D.,** Physician-in-Charge Fair Oaks Villa, Cuyahoga Falls, O. (*Associate.*)

1913 **Rogers, John B., M. D.,** Assistant Physician Napa State Hospital, Napa, Cal. (*Associate.*)

1912 **Rooks, J. T., M. D.,** Assistant Physician Kankakee State Hospital, Hospital, Ill. (*Associate.*)

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1909 **Rosanoff, A. J., M. D.,** First Assistant Physician Kings Park State Hospital, Kings Park, N. Y.

1915 **Ross, Chas. E., M. D.,** 110 Schweiter Bldg., Wichita, Kans.

1907 **Ross, Donald L., M. D.,** Assistant Physician Bloomingdale Hospital, White Plains, N. Y.

1912 **Ross, John R., M. D.,** First Assistant Physician Dannemora State Hospital, Dannemora, N. Y. (*Associate.*)

1899 **Rowe, John T. W., M. D.,** First Assistant Physician Manhattan State Hospital, Ward's Island, New York, N. Y.

1911 **Rowe, Melvin J., M. D.,** First Assistant Physician Mendocino State Hospital, Talmadge, Cal. (*Associate.*)

1912 **Rowland, George A., M. D.,** Assistant Physician Columbus State Hospital, Columbus, O. (*Associate.*)

1913 **Ruggles, Arthur H., M. D.,** Assistant Physician Butler Hospital, Providence, R. I.

1907 **Ruland, Frederick D., M. D.,** Proprietor Dr. Ruland's Sanitarium, Westport, Conn.

1912 **Runyon, Wm. D., M. D.,** Colorado Springs, Colo. (*Associate.*)

1913 **Russell, Clarence L., M. D.,** Assistant Physician Utica State Hospital, Utica, N. Y. (*Associate.*)

1912 **Russell, Rose A., M. D.,** Ft. Shaw, Mont. (*Associate.*)

1898 **Russell, Wm. L., M. D.,** Superintendent Bloomingdale Hospital, White Plains, N. Y.

1907 **Ryan, Edward, M. D.,** Superintendent Rockwood Hospital for the Insane, Kingston, Ontario.

1899 **Ryon, Walter G., M. D.,** Superintendent State Hospital, Poughkeepsie, N. Y.

S

1894 **Sachs, B., M. D.,** 116 W. 59th St., New York, N. Y.

1912 **Salmon, Thomas W., M. D.,** National Committee for Mental Hygiene, 50 Union Square, New York, N. Y.

1915 **Sanborn, Chas. F., M. D.,** Superintendent Cincinnati Hospital, Cincinnati, Ohio.

1916 **Sanders, H. G., M. D.,** Assistant Physician Western State Hospital, Hopkinsville, Ky. (*Associate.*)

1908 **Sandy, William C., M. D.,** Assistant Superintendent State Hospital, Middletown, Conn.

1913 **Sargent, George F., M. D.,** Assistant Physician Sheppard and Enoch Pratt Hospital, Towson, Md. (*Associate.*)

1913 **Saunders, Eleanora B., M. D.,** Waverley Sanitarium, Columbia, S. C. (*Associate.*)

1915 **Sawyer, Carl W., M. D.,** Sawyer Sanatorium, Marion, Ohio.

1909 **Scanland, J. M., M. D.,** Superintendent Montana State Hospital, Warm Springs, Mont.

1915 **Scheetz, Mildred E., M. D.,** Assistant Physician St. Elizabeth Hospital, Washington, D. C. (*Associate.*)

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1909 **Schlapp, Max G., M. D.,** Lecturer on Neuro-Histology and Pathology, Cornell University, 40 E. 41st St., New York City.

1914 **Schley, R. Montfort, M. D.,** 267 Elmwood Ave., Buffalo, N. Y.

1894 **Schmid, H. Ernest, M. D.,** White Plains, N. Y.

1912 **Scott, Thompson P., M. D.,** The Woodson Sanitarium, St. Joseph, Mo. (*Associate.*)

1886 **Scribner, Ernest V., M. D.,** Medical Superintendent Worcester State Hospital, Worcester, Mass.

1917 **Scrutchfield, G. E., M. D.,** Superintendent State Hospital No. 4, Farmington, Mo.

1893 **Searcy, James T., M. D.,** Medical Superintendent The Alabama Insane Hospitals, Tuscaloosa, Ala. (*President, 1913.*)

1894 **Searl, Wm. A., M. D.,** Medical Director Fair Oaks Villa, Cuyahoga Falls, Ohio.

1889 **Sefton, Frederick, M. D.,** The Pines, Auburn, N. Y.

1916 **Seiwell, Harry S., M. D.,** Illinois Soldiers' Home, Quincy, Ill. M. R. C., U. S. Army. (*Associate.*)

1897 **Semelaigne, Réné, M. D.,** Medecin en Chef Maison de Santé, Neuilly sur Seine, Paris, France. (*Honorary.*)

1892 **Semple, John M., M. D.,** Spokane, Wash.

1908 **Seybert, Frank T., M. D.,** Alienist St. Bernard's Hospital, 532 First Ave., Council Bluffs, Iowa.

1903 **Shanahan, Wm. T., M. D.,** Medical Superintendent Craig Colony for Epileptics, Sonyea, N. Y.

1903 **Sharp, Edw. A., M. D.,** 481 Franklin St., Buffalo, N. Y.

1915 **Sharp, Geo. A., M. D.,** Assistant Physician Mattewan State Hospital, Beacon, N. Y.

1913 **Shaw, Arthur L., M. D.,** Assistant Physician Craig Colony for Epileptics, Sonyea, N. Y.

1914 **Sheehan, Robert F., M. D.,** Naval Medical Officer, Washington, D. C. (*Associate.*)

1904 **Shepherd, Arthur F., M. D.,** 56 Auburn Ave., Columbus, O.

1912 **Sherman, Adin, M. D.,** Superintendent Northern Hospital for Insane, Winnebago, Wis.

1905 **Shirres, David Alexander, M. D.,** Consulting Neurologist to the Protestant Hospital for the Insane, 670 W. Sherbrooke St., Montreal, Can.

1912 **Sights, H. P., M. D.,** Paducah, Ky.

1914 **Simon, Theodore W., M. D.,** Senior Assistant Physician State Hospital, Central Islip, N. Y. (*Associate.*)

1892 **Simpson, J. C., M. D.,** 1421 Massachusetts Ave., Washington, D. C.

1915 **Sims, Haig A., M. D.,** Clinical Assistant Royal Victoria Hospital, 133 Darocher St., Montreal, Can.

1916 **Singer, H. Douglas, M. D.,** Director State Psychopathic Institute, Kankakee, Ill.

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1910 **Skinner, William W., M. D.,** Consulting Surgeon State Hospital, Willard, N. Y., 449 Main St., Geneva, N. Y.

1905 **Skoog, A. L., M. D.,** Associate Professor of Neurology University of Kansas, 1004 Rialto Building, Kansas City, Mo.

1904 **Slocum, Clarence J., M. D.,** Craig House, Beacon-on-Hudson, N. Y.

1915 **Smart, L. Gibbons, M. D.,** Medical Superintendent Creighton Sanitarium, Lutherville, Md.

1915 **Smiley, Alton L., M. D.,** Assistant Physician Colorado Insane Asylum, Pueblo, Colo. (*Associate.*)

1885 **Smith, Edwin Everett, M. D.** (formerly Medical Director New Jersey State Hospital), Kensett, Norwalk, Conn.

1898 **Smith, Geo. A., M. D.,** Medical Superintendent Central Islip State Hospital, Central Islip, L. I., N. Y.

1902 **Smith, Gilbert T., M. D.,** Mansfield State Training School, Mansfield Depot, Conn. (*Associate.*)

1913 **Smith, H. V. A., M. D.,** Superintendent Hudson Co. Hospital for Insane, Jersey City, N. J.

1915 **Smith, Henry G., M. D.,** Assistant Physician Essex County Hospital, Cedar Grove, N. J. (*Associate.*)

1913 **Smith, J. Anson, M. D.,** Camden County Hospital for Insane, Blackwood, N. J.

1913 **Smith, J. G. Fowble, M. D.,** Brunswick, Md. (*Associate.*)

1911 **Smith, Joseph, M. D.,** Assistant Physician Long Island State Hospital, Brooklyn, N. Y. (*Associate.*)

1912 **Smith, Robert P., M. D.,** Cobb Building, Seattle, Wash.

1891 **Smith, S. E., M. D.,** Medical Superintendent Eastern Indiana Hospital for the Insane, "Easthaven," Richmond, Ind. (*President, 1915.*)

1885 **Smith, Stephen, M. D.,** 300 Central Park, West, New York, N. Y. (*Honorary.*)

1914 **Smithson, Wm. W., M. D.,** Superintendent State Insane Hospital, Asylum, Miss.

1917 **Smyth, Margaret H., M. D.,** Assistant Physician State Hospital, Stockton, Cal. (*Associate.*)

1911 **Snavely, Earl H., M. D.,** Assistant Physician Essex County Hospital for Insane, Cedar Grove, N. J. (*Associate.*)

1908 **Solier, Charles H., M. D.,** Superintendent State Hospital, Evanston, Wyo.

1916 **Solomon, Harry C., M. D.,** Junior Assistant Physician Psychopathic Hospital, Boston, Mass. (*Associate.*)

1898 **Somers, Elbert M., M. D.,** 33 Lefferts Place, Brooklyn, N. Y.

1913 **Somerville, William G., M. D.,** Neurologist City Hospital, Memphis, Tenn.

1916 **Sommer, Henry J., M. D.,** Superintendent Blair County Hospital for Insane, Hollidaysburg, Pa.

1907 **Southard, Elmer E., M. D.,** Director Psychopathic Department, Boston State Hospital, 70 Francis Ave., Cambridge, Mass. (*Vice-President, 1918.*)

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1913 **Spalding, Harry O., M. D.,** Superintendent Westborough State Hospital, Westborough, Mass.

1915 **Spaulding, Edith R., M. D.,** Laboratory of Social Hygiene, Bedford Hills, N. Y. (*Associate.*)

1914 **Spear, Irving J., M. D.,** 1810 Madison Ave., Baltimore, Md.

1899 **Spence, James Beveridge, M. D., R. U. I., M. Ch.,** Resident Physician and Superintendent Staffordshire County Asylum, Burntwood, near Litchfield, England. (*Honorary.*)

1894 **Sprague, Geo. P., M. D.,** Superintendent High Oaks Sanitarium, Lexington, Ky.

1914 **Stack, S. S., M. D.,** Superintendent Sacred Heart Sanitarium and St. Mary's Hill Hospital, Milwaukee, Wis.

1914 **Stancell, W. W., M. D.,** Assistant Physician State Hospital, Raleigh, N. C. (*Associate.*)

1892 **Stanley, Charles E., M. D.,** Assistant Physician Connecticut Hospital for the Insane, Middletown, Conn. (*Associate.*)

1913 **Stearns, Albert Warren, M. D.,** 520 Commonwealth Ave., Boston, Mass.

1898 **Stearns, Wm. G., M. D.,** 25 E. Washington St., Chicago, Ill.

1914 **Steckel, Harry A., M. D.,** Assistant Physician Kings Park State Hospital, Kings Park, N. Y. (*Associate.*)

1884 **Stedman, Henry R., M. D.,** Bournewood Private Hospital for Nervous and Mental Diseases, South St., Brookline, Mass.

1895 **Stevens, Frank T., M. D.,** 609 Exchange National Bank Building, Colorado Springs, Colo.

1915 **Stevenson, W. W., M. D.,** Assistant Physician Trenton State Hospital, Trenton, N. J. (*Associate.*)

1914 **Stewart, Robert A., M. D.,** Assistant Physician Mt. Pleasant State Hospital, Mt. Pleasant, Ia. (*Associate.*)

1907 **Stick, H. Louis, M. D.,** Superintendent Hospital Cottages for Children, Baldwinsville, Mass.

1909 **Stone, Elmer E., M. D.** (formerly Superintendent Napa State Hospital, Napa, Cal.), 291 Geary St., San Francisco, Cal.

1892 **Stone, William A., M. D.** (formerly Assistant Superintendent Michigan Asylum for the Insane), 1102 W. Main St., Kalamazoo, Mich.

1914 **Strecker, Edward A., M. D.,** Assistant Physician Pennsylvania Hospital, Department for Mental and Nervous Diseases, West Philadelphia, Pa. M. R. C., U. S. Army. (*Associate.*)

1913 **Sturgis, Karl B., M. D.,** Assistant Physician Maine Insane Hospital, Augusta, Me. (*Associate.*)

1912 **Sullivan, F. J., M. D.,** Kankakee State Hospital, Hospital, Ill. (*Associate.*)

1903 **Swift, Henry M., M. D.,** 655 Congress St., Portland, Me.

1914 **Swift, Walter B., M. D.,** 110 Bay State Road, Boston, Mass.

1894 **Sylvester, William E., M. D.,** Thendara, Canandaigua Lake, N. Y.

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T

1899 **Taddiken, Paul Gerald, M. D.,** First Assistant Physician St. Lawrence State Hospital, Ogdensburg, N. Y. (*Associate.*)

1915 **Taft, Annie E., M. D.,** Curator, Department of Neuropathology Harvard University, 240 Longwood Ave., Boston, Mass. (*Associate.*)

1881 **Tamburini, A., M. D.,** Reggio-Emilia, Italy. (*Honorary.*)

1914 **Taylor, Herbert W., M. D.,** First Assistant Physician Brattleboro Retreat, Brattleboro, Vt. (*Associate.*)

1892 **Taylor, Isaac M., M. D.,** Superintendent Broadoaks Sanatorium, Morganton, N. C.

1915 **Taylor, Melvin J., M. D.,** Assistant Physician Hudson River State Hospital, Poughkeepsie, N. Y. (*Associate.*)

1915 **Taylor, Wesley, M. D.,** Detroit, Mich.

1910 **Terflinger, Fred. W., M. D.,** Medical Superintendent Northern Hospital for Insane, Logansport, Indiana.

1916 **Terhune, Wm. Barclay, M. D.,** 4516 Perrier St., New Orleans, La. U. S. Army.

1915 **Thom, Douglas A., M. D.,** Grafton State Hospital, Worcester, Mass. (*Associate.*)

1914 **Thomas, John N., M. D.,** Superintendent Louisiana Hospital for Insane, Pineville, La.

1906 **Thompson, Charles E., M. D.,** Superintendent Gardner State Colony, Gardner, Mass.

1915 **Thompson, Chas. W., M. D.,** Assistant Superintendent Woodcroft, Pueblo, Colo.

1891 **Thompson, J. L., M. D.,** Assistant Physician State Hospital for the Insane, Columbia, S. C. (*Associate.*)

1896 **Thompson, Whitefield N., M. D.,** Medical Superintendent The Hartford Retreat, Hartford, Conn.

1915 **Thomson, E. Mabel, M. D.,** Woman Physician Craig Colony for Epileptics, Sonyea, N. Y. (*Associate.*)

1914 **Thorne, Frederic H., M. D.,** Pathologist New Jersey State Hospital, Morris Plains, N. J. (*Associate.*)

1912 **Throckmorton, Tom B., M. D.,** 407 Equitable Building, Des Moines, Ia.

1914 **Thurlow, A. A., M. D.,** First Assistant Physician Oklahoma Hospital for Insane, Norman, Okla. (*Associate.*)

1912 **Tiffany, William J., M. D.,** Senior Assistant Physician Binghamton State Hospital, Binghamton, N. Y. (*Associate.*)

1912 **Todd, Leona E., M. D.,** Woman Physician Hudson River State Hospital, Poughkeepsie, N. Y. (*Associate.*)

1912 **Toomey, Joseph H., M. D.,** Laboratory Police Department N. Y. City. (*Associate.*)

1901 **Torney, Geo. H., Jr., M. D.,** Associate Physician Bournewood Hospital, South St., Brookline, Mass.

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1902 **Toulouse, Edouard, M. D.,** Physician-in-Chief to Villejuif Asylum; Director Revue de Psychiatrie; Director of Laboratory of Experimental Psychology, l'Ecole des Hautes Etudes, Paris; Villejuif (Seine), France. (*Honorary.*)

1899 **Townsend, Theodore Irving, M. D.,** First Assistant Physician Binghamton State Hospital, Binghamton, N. Y.

1913 **Trader, Wm. N., M. D.,** Assistant Physician Craig Colony for Epileptics, Sonyea, N. Y. (*Associate.*)

1914 **Travis, John H., M. D.,** Senior Assistant Boston State Hospital, Psychopathic Department, Boston, Mass. (*Associate.*)

1912 **Treadway, Walter L., M. D.,** Assistant Surgeon U. S. Public Health Service, Ellis Island, New York.

1912 **Trenkle, Henry L., M. D.,** Physician-in-Charge Knickerbocker Hall, Amityville, L. I. (*Associate.*)

1915 **Troxell, Geo. Allen, M. D.,** Assistant Physician Medfield State Hospital, Harding, Mass. (*Associate.*)

1914 **Trueman, Nelson G., M. D.,** Assistant Physician Danvers State Hospital, Hathorne, Mass. (*Associate.*)

1912 **Truitt, R. P., M. D.,** State Hospital, Trenton, N. J.

1901 **Turner, John S., M. D.,** 326-27 Linz Bldg., Dallas, Texas.

1913 **Turner, Reeve, M. D.,** 522 W. 149th St., New York, N. Y.

1892 **Tuttle, Geo. T., M. D.,** Medical Superintendent McLean Hospital, Waverley, Mass.

1908 **Twohey, John J., M. D.,** Physician-in-Charge Providence Retreat, Buffalo, N. Y.

1909 **Tyson, Forrest C., M. D.,** Superintendent Augusta State Hospital, Augusta, Me.

U

1909 **Uhls, L. L., M. D.,** The Uhls Sanitarium, Overland Park, Kans.

1914 **Ullman, Albert E., M. D.,** Senior Assistant Physician State Hospital, Central Islip, N. Y. (*Associate.*)

1917 **Unsworth, Charles V., M. D.,** Orleans Parish Hospital, New Orleans, La.

1899 **Urquhart, Alexander R., M. D., F. R. C. P. E.,** Superintendent Royal Asylum, Perth, Scotland. (*Honorary.*)

V

1915 **Van Nuys, Walter C., M. D.,** Superintendent Indiana Village for Epileptics, Newcastle, Ind.

1911 **VanWart, Roy McLean, M. D.,** Professor Psychiatry Tulane University, 1126 Maison Blanche Building, New Orleans, La.

1913 **Vaux, Charles L., M. D.,** Senior Assistant Physician, State Hospital, Central Islip, N. Y. (*Associate.*)

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1912 **Veeder, Willard H., M. D.,** Assistant Physician Rochester State Hospital, Rochester, N. Y. (*Associate.*)

1893 **Voldeng, M. Nelson, M. D.,** Superintendent The State Hospital and Colony Epileptics, Woodward, Iowa.

1912 **Vosburgh, Stephen E., M. D.,** Assistant Superintendent Maine Insane Hospital, Augusta, Me. (*Associate.*)

W

1895 **Wade, J. Percy, M. D.,** Medical Superintendent Spring Grove State Hospital, Catonsville, Md.

1890 **Wagner, Charles G., M. D.,** Medical Superintendent Binghamton State Hospital, Binghamton, N. Y. (*President, 1917.*)

1912 **Walker, Eloise, M. D.,** Woman Physician, Binghamton State Hospital, Binghamton, N. Y. (*Associate.*)

1905 **Walker, Irving Lee, M. D.,** Assistant Physician Rochester State Hospital, Rochester, N. Y. (*Associate.*)

1905 **Walker, Lewis M., M. D.,** Assistant Physician Pennsylvania Hospital, Department for Nervous and Mental Diseases, West Philadelphia, Pa.

1914 **Walker, N. P., M. D.,** Assistant Physician Georgia State Sanitarium, Milledgeville, Ga. (*Associate.*)

1916 **Walker, W. K., M. D.,** St. Francis Hospital, Pittsburgh, Pa.

1917 **Walsh, Wm. S., M. D.,** Assistant Physician Maine School for Feeble-Minded, West Pownal, Me. (*Associate.*)

1913 **Wardner, Drew M., M. D.,** 571 Park Ave., New York, N. Y. (*Associate.*)

1912 **Washburn, Philip C., M. D.,** Assistant Physician Kings Park State Hospital, Kings Park, N. Y. (*Associate.*)

1912 **Waterman, Chester, M. D.,** Assistant Physician Manhattan State Hospital, Ward's Island, N. Y. (*Associate.*)

1914 **Waterman, Paul, M. D.,** Major M. R. C., U. S. Army.

1916 **Waters, Pearl S., M. D.,** Assistant Physician Fergus Falls State Hospital, Fergus Falls, Minn. (*Associate.*)

1913 **Webster, B. R., M. D.,** Assistant Physician Matteawan State Hospital, Beacon, N. Y. (*Associate.*)

1910 **Weeks, David F., M. D.,** Medical Superintendent and Executive Officer New Jersey State Village for Epileptics, Skillman, N. J.

1913 **Weisenburg, T. H., M. D.,** 2030 Chestnut St., Philadelphia, Pa.

1893 **Welch, G. O., M. D.,** Medical Superintendent Fergus Falls State Hospital, Fergus Falls, Minn.

1916 **Wellington, Anna C., M. D.,** Assistant Physician Psychopathic Hospital, Boston, Mass. (*Associate.*)

1915 **Wen Gleaky, J. F., M. D.,** Resident Physician St. Mary's Hill, Milwaukee, Wis.

1892 **Wentworth, Lowell F., M. D.,** Assistant Director Commission on Mental Diseases, 36 State House, Boston, Mass.

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1914 **Wescott, Adeline M., M. D.,** St. Luke's Hospital, Newburgh, N. Y. (*Associate.*)

1904 **West, Calvin B., M. D.,** Senior Assistant Physician Hudson River State Hospital, Poughkeepsie, N. Y. (*Associate.*)

1916 **West Carl A., M. D.,** Assistant Physician State Hospital, Columbia, S. C. M. R. C., U. S. Army. (*Associate.*)

1912 **Weston, Paul G., M. D.,** Pathologist State Hospital, Warren, Pa. (*Associate.*)

1912 **White, F. S., M. D.,** Terrell, Tex.

1906 **White, Grace E., M. D.,** Wood Lea Sanitarium, 300 Ardmore Ave., Ardmore, Pa. (*Associate.*)

1902 **White, Wm. A., M. D.,** Superintendent St. Elizabeth Hospital, Washington, D. C.

1916 **White, Wm. B., M. D.,** Assistant Physician Dixmont State Hospital, Dixmont, Pa. (*Associate.*)

1912 **Whitney, Ray L., M. D.,** Assistant Physician McLean Hospital, Waverley, Mass. (*Associate.*)

1916 **Whitten, Benjamin O., M. D.,** Assistant Physician State Hospital, Columbia, S. C. (*Associate.*)

1914 **Wholey, Cornelius C., M. D.,** 1018 Westinghouse Bldg., Pittsburgh, Pa.

1915 **Wickers, Mary, M. D.,** Woman Physician Eastern Indiana Hospital, Richmond, Ind. (*Associate.*)

1903 **Wilcox, Franklin S., M. D.,** Assistant Superintendent Southern California State Hospital, Patton, Cal. (*Associate.*)

1898 **Wilgus, Sidney D., M. D.,** Superintendent and Proprietor The Ransom Sanitarium, Box 304, Rockford, Ill.

1913 **Williams, B. F., M. D.,** Lincoln, Nebr.

1906 **Williams, Berthold A., M. D.,** Senior Resident Physician, Cincinnati Sanitarium, College Hill, Ohio.

1916 **Williams, C. F., M. D.,** Superintendent State Hospital for Insane. Columbia, S. C.

1916 **Williams, Frankwood E., M. D.,** Associate Director National Society for Mental Hygiene, 50 Union Sq., N. Y. U. S. Army.

1904 **Williams, G. H., M. D.,** Assistant Physician Columbus State Hospital, Columbus, Ohio.

1910 **Williams, Tom A., M. D.,** 1705 W St., N. W., Washington, D. C.

1884 **Williamson, Alonzo P., M. D.,** 842 N. 2d St., Santa Monica, Cal.

1888 **Wilsey, O. J., M. D.,** Physician-in-Charge Long Island Home, Amityville, N. Y.

1910 **Wilson, William T., M. D.,** Superintendent Hospital for the Insane, Penetanguishene, Ont.

1907 **Winterode, Robert P., M. D.,** Superintendent Crownsville State Hospital, Crownsville, Md.

1912 **Wiseman, John L., M. D.,** Lieut. M. R. C., U. S. Army. (*Associate.*)

1913 **Wiswall, Edward H., M. D.,** Proprietor Wellesley Nervine, Wellesley, Mass.

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1895 **Witte, M. E., M. D.,** Medical Superintendent Clarinda State Hospital, Clarinda, Ia.

1902 **Wolfe, Mary Moore, M. D.,** 29 S. 3d St., Lewisburg, Pa.

1913 **Wolff, George B., M. D.,** Clinical Assistant Sheppard and Enoch Pratt Hospital, Towson, Md. (*Associate.*)

1910 **Woodbury, Frank, M. D.,** Secretary Committee on Lunacy State of Pennsylvania, 717 Bulletin Building, Philadelphia, Pa.

1907 **Woodman, Robert C., M. D.,** First Assistant Physician Middletown State Homeopathic Hospital, Middletown, N. Y. (*Associate.*)

1890 **Woodson, C. R., M. D.,** Dr. C. R. Woodson's Sanitarium, St. Joseph, Mo.

1911 **Woodward, Esther S. B., M. D.,** Box 13, Brooks Station, Mass.

1901 **Work, Hubert, M. D.,** Superintendent Woodcroft Hospital for Nervous Diseases, Pueblo, Col. (*President, 1912.*)

1916 **Work, Philip, M. D.,** Neurologist, Woodcroft Hospital, Pueblo, Colo. (*Associate.*)

1915 **Wright, Harold W., M. D.,** Physicians' Bldg., San Francisco, Cal.

1893 **Wright, W. E., M. D.,** 204-206 State St., Harrisburg, Pa. (*Associate.*)

1912 **Wright, Wm. W., M. D.,** Psychiatric Institute, Ward's Island, New York, N. Y. (*Associate.*)

Y

1912 **Yarbrough, Y. H., M. D.,** Assistant Physician Georgia State Sanitarium, Milledgeville, Ga.

1894 **Yellowlees, David, M. D., L. R. C. S., Edin., F. F. P. S.** and **LL. D.,** Glasgow (formerly Physician Superintendent Glasgow Royal Asylum, Gartnavel), 6 Albert Gate, Dowanhill, Glasgow, Scotland. (*Honorary.*)

1917 **Young, A. F., M. D.,** Superintendent Milwaukee Hospital for Insane, Milwaukee, Wis.

1917 **Young, Beverly, M. D.,** Superintendent Southwestern Insane Asylum, San Antonio, Tex.

1906 **Young, David, M. D.** (formerly Superintendent Asylum for the Insane, Selkirk, Manitoba, Canada), 494 Camden Place, Winnipeg, Manitoba, Canada.

1915 **Young, Ernest H., M. D.,** Assistant Superintendent Rockwood Hospital, Kingston, Ontario, Can.

1914 **Young, Hugh Hampton, M. D.,** President State Lunacy Commission of Maryland, 330 N. Charles St., Baltimore, Md. (*Honorary.*)

1906 **Youngling, George S., M. D.,** Consulting Physician Central Islip State Hospital, 453 W. 34th St., New York, N. Y.

1913 **Yule, Lorne W., M. D.,** Assistant Physician Northern Hospital for Insane, Logansport, Ind. (*Associate.*)

Z

1906 **Zeller, George A., M. D.,** Superintendent Alton State Hospital, Alton, Ill.

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LIFE MEMBERS

1872 **Theodore H. Kellogg, M. D.**, New York, N. Y.
1874 **Carlos F. MacDonald, M. D.**, New York, N. Y.
1879 **Hosea M. Quinby, M. D.**, Worcester, Mass.
1879 **Henry M. Hurd, M. D.**, Baltimore, Md.
1880 **Walter Channing, M. D.**, Brookline, Mass.
1881 **Edward Cowles, M. D.**, Plymouth, Mass.
1881 **Richard Dewey, M. D.**, Wauwatosa, Wis.
1882 **Shailer E. Lawton, M. D.**, Brattleboro, Vt.
1882 **Samuel B. Lyon, M. D.**, White Plains, N. Y.
1883 **Gershom H. Hill, M. D.**, Des Moines, Ia.
1883 **Charles G. Hill, M. D.**, Baltimore, Md.
1883 **Robert H. Chase, M. D.**, Philadelphia, Pa.
1883 **Sanger Brown, M. D.**, Kenilworth, Ill.
1883 **Charles P. Bancroft, M. D.**, Concord, N. H.
1884 **Henry R. Stedman, M. D.**, Brookline, Mass.
1884 **Alonzo P. Williamson, M. D.**, Santa Monica, Cal.
1885 **Edwin E. Smith, M. D.**, Norwalk, Conn.
1885 **Charles K. Clark, M. D.**, Toronto, Can.
1885 **Michael Campbell, M. D.**, Bearden, Tenn.
1885 **Henry A. Hutchinson, M. D.**, Dixmont, Pa.
1886 **G. Alder Blumer, M. D.**, Providence, R. I.
1886 **Wm. D. Granger, M. D.**, Bronxville, N. Y.
1886 **L. S. Hinckley, M. D.**, Newark, N. J.
1886 **James D. Munson, M. D.**, Traverse City, Mich.
1886 **Edward B. Nims, M. D.**, Springfield, Mass.
1886 **Ernest V. Scribner, M. D.**, Worcester, Mass.
1887 **N. Emmons Paine, M. D.**, West Newton, Mass.
1888 **Daniel A. Harrison, M. D.**, Whitestone, L. I.
1888 **Eugene H. Howard, M. D.**, Rochester, N. Y.
1888 **O. J. Wilsey, M. D.**, Amityville, N. Y.

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HONORARY MEMBERS

1890 **Henry M. Bannister, M. D.**, Evanston, Ill.
1898 **James M. Buckley, D. D., LL. D.**, Morristown, N. J.
1908 **Shepherd I. Franz, A. B., Ph. D.**, Washington, D. C.
1891 **G. Stanley Hall, Ph. D., LL. D.**, Worcester, Mass.
1899 **Henry Hun, M. D.**, Albany, N. Y.
1896 **Jules Morel, M. D.**, Mons, Belgium.
1881 **A. Motet, M. D.**, Paris, France.
1894 **A. Victor Parant, M. D.**, Toulouse, France.
1896 **Emmanuel Régis, M. D.**, Bordeaux, France.
1899 **Antoine Ritti, M. D.**, Charenton, près Paris, France.
1897 **Réné Semelaigne, M. D.**, Paris, France.
1885 **Stephen Smith, M. D.**, New York, N. Y.
1899 **James Beveridge Spence, M. D., M. C. Q. U. I.**, Burntwood, England.
1881 **A. Tamburini, M. D.**, Reggio-Emilia, Italy.
1902 **Edouard Toulouse, M. D.**, Villejuif, France.
1894 **David Yellowlees, M. D., F. R. F. P. and S., LL. D.**, Glasgow, Scotland.
1914 **Hugh Hampton Young, M. D.**, Baltimore, Md.

Total Membership:

Active	486
Associate	368
Life	30
Honorary	17
Total	901

The following tabulation shows the membership of the Association for the past decade:

Members	1909	1910	1911	1912	1913	1914	1915	1916	1917	1918
Active	325	339	337	360	398	457	457	465	475	486
Associate	117	134	134	133	203	250	289	323	342	368
Life	.....	.....	.....	.....	.....	.....	17	21	27	30
Honorary	24	24	22	21	20	19	19	18	18	17
Total	466	497	493	514	621	726	782	827	862	901

NOTE.—It will be observed that the list of members as here printed shows the date when each member became identified with the Association. This arrangement is believed to be a valuable addition to the list which will be appreciated.

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NECROLOGY

George Smith Adams, M. D., Stamford, Ct. Died March 16, 1913.
Henry S. Upson, M. D., Cleveland, O. Died April 23, 1913.
H. A. Tomlinson, M. D., Willmar, Minn. Died May 30, 1913.
E. H. Pomeroy, M. D., Bradentown, Fla. Died June 22, 1913.
S. Weir Mitchell, M. D., Philadelphia, Pa. Died Jan. 4, 1914.
Edward W. King, M. D., San Francisco, Cal. Died Jan. 11, 1914.
Thomas J. Moher, M. D., Cobourg, Ont. Died Feb. 24, 1914.
Henry C. Baldwin, M. D., Boston, Mass. Died February 25, 1914.
Ralph L. Parsons, M. D., Ossining, N. Y. Died Feb. 26, 1914.
R. J. Dysart, M. D., Winnebago, Wis. Died May 26, 1914.
Brooks F. Beebe, M. D., Cincinnati, O. Died May 29, 1914.
Wm. B. Moseley, M. D., Brooklyn, N. Y. Died June 26, 1914.
Samuel F. Mellen, M. D., Poughkeepsie, N. Y. Died July 15, 1914.
Oscar R. Long, M. D., Ionia, Mich. Died Sept. 9, 1914.
Theodore Fisher, M. D., Boston, Mass. Died October 10, 1914.
Wesley Mills, M. D., Montreal, Que. Died February 13, 1915.
Henry S. Noble, M. D., Middletown, Conn. Died March 16, 1915.
Albert R. Moulton, M. D., Philadelphia, Pa. Died August 16, 1915.
John M. Bemis, M. D., Worcester, Mass. Died September 22, 1915.
Austin Flint, M. D., New York, N. Y. Died September 22, 1915.
Wm. Noyes, M. D., Jamaica Plains, Mass. Died October 20, 1915.
Alfred I. Noble, M. D., Kalamazoo, Mich. Died January 20, 1916.
R. W. Bruce Smith, M. D., Toronto, Canada.
C. F. Gilliam, M. D., Columbus O. Died April 12, 1916.
Geo. H. Schwinn, M. D., Washington, D. C.
R. F. Parsons, M. D., Mt. Holly, N. J.
Victor A. Bles, M. D., Elgin, Ill.
Charles H. Hughes, M. D., St. Louis, Mo. Died July 13, 1916.
C. Von A. Schneider, M. D.
Wm. Mabon, M. D., Died February 9, 1917.
Elliott Gorton, M. D., Died March 3, 1917.
Moses J. White, M. D., Died March 14, 1917.
Henry P. Frost, M. D., Died May 23, 1917.
G. H. Moody, M. D., Died April 29, 1917.
Charles H. North, M. D., Died December 12, 1917.
John B. Chapin, M. D., Died January 17, 1918.
George Villeneuve, M. D., Died January 21, 1918.
Thomas C. Biddle, M. D., Died February 16, 1918.

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PRESIDENTS OF THE ASSOCIATION

Samuel B. Woodward, M. D., Worcester, Mass.....1844-1848
William McClay Awl, M. D., Columbus, Ohio.....1848-1851
Luther V. Bell, M. D., Somerville, Mass.....1851-1855
Isaac Ray, M. D., Providence, R. I.....1855-1859
Andrew McFarland, M. D., Concord, N. H.....1859-1862
Thomas S. Kirkbride, M. D., Philadelphia, Pa.....1862-1870
John S. Butler, M. D., Hartford, Ct.....1870-1873
Charles H. Nichols, M. D., Bloomingdale, N. Y.....1873-1879
Clement A. Walker, M. D., Boston, Mass.....1879-1882
John H Callender, M. D., Nashville, Tenn.....1882-1883
John P. Gray, M. D., Utica, N. Y.....1883-1884
Pliny Earle, M. D., Northampton, Mass.....1884-1885
Orpheus Everts, M. D., Cincinnati, Ohio.....1885-1886
H. A. Buttolph, M. D., Short Hills, N. J.....1886-1887
Eugene Grissom, M. D., Raleigh, N. C.....1887-1888
John B. Chapin, M. D., Philadelphia, Pa.....1888-1889
W. W. Godding, M. D., Washington, D. C.....1889-1890
H. P. Stearns, M. D., Hartford, Ct.....1890-1891
Daniel Clark, M. D., Toronto, Canada.....1891-1892
J. B. Andrews, M. D., Buffalo, N. Y.....1892-1893
John Curwen, M. D., Warren, Pa.....1893-1894
Edward Cowles, M. D., Somerville, Mass.....1894-1895
Richard Dewey, M. D., Wauwatosa, Wis.....1895-1896
Theophilus O. Powell, M. D., Milledgeville, Ga.....1896-1897
Richard M. Bucke, M. D., London, Ontario.....1897-1898
Henry M. Hurd, M. D., Baltimore, Md.....1898-1899
Joseph G. Rogers, M. D., Logansport, Ind.....1899-1900
Peter M. Wise, M. D., New York, N. Y.....1900-1901
Robert J. Preston, M. D., Marion, Va.....1901-1902
G. Alder Blumer, M. D., Providence, R. I.....1902-1903
A. B. Richardson, M. D., Washington, D. C. } ..(died before taking office)
A. E. Macdonald, M. D., New York, N. Y.. } 1903-1904
T. J. W. Burgess, M. D., Montreal, Canada.....1904-1905
C. B. Burr, M. D., Flint, Mich.....1905-1906
Charles G. Hill, M. D., Baltimore, Md.....1906-1907
Charles P. Bancroft, M. D., Concord, N. H.....1907-1908
Arthur F. Kilbourne, M. D., Rochester, Minn.....1908-1909
William F. Drewry, M. D., Petersburg, Va.....1909-1910
Charles W. Pilgrim, M. D., Poughkeepsie, N. Y.....1910-1911
Hubert Work, M. D., Pueblo, Col.....1911-1912
James T. Searcy, M. D., Tuscaloosa, Ala.....1912-1913
Carlos F. MacDonald, M. D., New York, N. Y.....1913-1914
Samuel E. Smith, M. D., Richmond, Ind.....1914-1915
Edward N. Brush, M. D., Baltimore, Md.....1915-1916
Charles G. Wagner, M. D., Binghamton, N. Y.....1916-1917
James V. Anglin, M. D., St. John, N. B.....1917-1918

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SECRETARIES OF THE ASSOCIATION

Thomas S. Kirkbride, M. D., Philadelphia, Pa.....1844-1852
H. A. Buttolph, M. D., Short Hills, N. J.....1852-1854
Charles H. Nichols, M. D., Washington, D. C.....1854-1858
John Curwen, M. D., Warren, Pa.....1858-1893
Henry M. Hurd, M. D., Baltimore, Md.....1893-1897
C. B. Burr, M. D., Flint, Mich.....1897-1904
E. C. Dent, M. D., New York, N. Y.....1904-1906
Charles W. Pilgrim, M. D., Poughkeepsie, N. Y.....1906-1909
Charles G. Wagner, M. D., Binghamton, N. Y.....1909-1915
Henry C. Eyman, M. D., Massillon, Ohio.....1915-

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MEETING PLACES OF ASSOCIATION OF MEDICAL SUPERINTENDENTS OF AMERICAN INSTITUTIONS FOR THE INSANE

1st	1844	Philadelphia, Pa., Jones Hotel, Oct. 16, 1844. Pres., Dr. Samuel B. Woodward. Vice-Pres., Dr. Samuel White. Sec.-Treas., Dr. Thomas S. Kirkbride.
	1845	No meeting held.
2d	1846	Washington, D. C.
	1847	No meeting held.
3d	1848	New York, N. Y.
4th	1849	Utica, N. Y.
5th	1850	Boston, Mass.
6th	1851	Philadelphia, Pa.
7th	1852	New York, N. Y.
8th	1853	Baltimore, Md.
9th	1854	Washington, D. C.
10th	1855	Boston, Mass.
11th	1856	Cincinnati, Ohio.
12th	1857	New York, N. Y.
13th	1858	Quebec, Que.
14th	1859	Lexington, Ky.
15th	1860	Philadelphia, Pa.
	1861	No meeting held on account of the disturbed condition of the country.
16th	1862	Providence, R. I.
17th	1863	New York, N. Y.
18th	1864	Washington, D. C.
19th	1865	Pittsburgh, Pa.
20th	1866	Washington, D. C.
21st	1867	Philadelphia, Pa.
22d	1868	Boston, Mass.
23d	1869	Staunton, Va.
24th	1870	Hartford, Conn.
25th	1871	Toronto, Ont.
26th	1872	Madison, Wis.
27th	1873	Baltimore, Md.
28th	1874	Nashville, Tenn.
29th	1875	Auburn, N. Y.
30th	1876	Philadelphia, Pa.
31st	1877	St. Louis, Mo.
32d	1878	Washington, D. C.
33d	1879	Providence, R. I.
34th	1880	Philadelphia, Pa.
35th	1881	Toronto, Ont.
36th	1882	Cincinnati, Ohio.
37th	1883	Newport, R. I.
38th	1884	Philadelphia, Pa.
39th	1885	Saratoga, N. Y.
40th	1886	Lexington, Ky.
41st	1887	Detroit, Mich.
42d	1888	Fortress Monroe, Va.
43d	1889	Newport, R. I.
44th	1890	Niagara Falls, N. Y.
45th	1891	Washington, D. C.
46th	1892	Washington, D. C. New constitution adopted. Name changed to American Medico-Psychological Ass'n.
47th	1893	Chicago, Ill.
50th	1894	Philadelphia, Pa. Fiftieth year since foundation. Semi-centennial. Number of meetings changed. Proceedings published in separate volume.
51st	1895	Denver, Col.
52d	1896	Boston, Mass.
53d	1897	Baltimore, Md.
54th	1898	St. Louis, Mo.
55th	1899	New York, N. Y.
56th	1900	Richmond, Va.
57th	1901	Milwaukee, Wis.
58th	1902	Montreal, Que.
59th	1903	Washington, D. C.
60th	1904	St. Louis, Mo.
61st	1905	San Antonio, Tex.
62d	1906	Boston, Mass.
63d	1907	Washington, D. C.
64th	1908	Cincinnati, Ohio.
65th	1909	Atlantic City, N. J.
66th	1910	Washington, D. C.
67th	1911	Denver, Col.
68th	1912	Atlantic City, N. J.
69th	1913	Niagara Falls, Ont.
70th	1914	Baltimore, Md.
71st	1915	Fortress Monroe, Va.
72d	1916	New Orleans, La.
73d	1917	New York, N. Y.
74th	1918	Chicago, Ill.

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GEOGRAPHICAL DISTRIBUTION

—OF—

MEMBERS AND INSTITUTIONS

A

ALABAMA—The Alabama Insane Hospitals.

No members.

The Bryce Hospital, Tuscaloosa.

James T. Searcy, M. D., Medical Superintendent.

William D. Partlow, M. D., Assistant Superintendent.

The Mt. Vernon Hospital (for Negroes), Mt. Vernon.

James T. Searcy, M. D., Superintendent.

Emit L. McCafferty, M. D., Assistant Superintendent.

Eugene D. Bondurant, M. D., Mobile.

ALASKA.

Arthur C. Delacroix, M. D., Douglas.

ARIZONA—State Insane Asylum, Phoenix.

Alfred C. Kingsley, M. D., Superintendent.

Harlan P. Mills, M. D., Assistant Physician.

U. S. Government Hospital, Leupp.

No members.

Mary Lawson Neff, M. D., Phoenix.

ARKANSAS—State Hospital for Nervous Diseases, Little Rock.

R. F. Darnall, M. D., Clinical Director and Assistant Superintendent.

Edwin P. Bledsoe, M. D., Little Rock.

James L. Green, M. D., Hot Springs.

C

CALIFORNIA—Agnew State Hospital, Agnew.

Glenn E. Myers, M. D., Assistant Physician.

California State Hospitals.

F. W. Hatch, M. D., General Superintendent, Sacramento.

Elmwoods Sanitarium, Haywood.

Frederick E. Allen, Physician-in-Charge.

Livermore Sanitarium, Livermore.

Clifford W. Mack, M. D., Superintendent.

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CALIFORNIA—*Continued.*

Los Angeles County Psychopathic Hospital.
Charles Lewis Allen, Physician-in-Charge.

Mendocino State Hospital, Talmage.
Robert L. Richards, M. D., Superintendent.
Melvin J. Rowe, M. D., First Assistant.

Napa State Hospital, Napa.
Andrew W. Hoisholt, M. D., Superintendent.
Adelbert C. Matthews, M. D., First Assistant Physician.
John B. Rogers, M. D., Assistant Physician.

Norwalk State Hospital, Norwalk.
W. B. Kern, M. D., Superintendent.
Grover T. DeLaHoyde, M. D., Assistant Physician.

Sonoma State Home for Feeble-Minded and Epileptic, Eldridge.
No members.

Southern California State Hospital, Patton.
John A. Reily, M. D., Superintendent.
Franklin S. Wilcox, M. D., Assistant Superintendent.

Stockton State Hospital, Stockton.
Fred. P. Clark, M. D., Superintendent.
Margaret Smyth, M. D., Assistant Physician.

Charles L. Allen, M. D., Los Angeles.
Jau Don Ball, M. D., Oakland.
Daniel H. Calder, M. D., Pasadena.
Gilbert V. Hamilton, M. D., Montecito.
August Hoch, M. D., Riven Rock, Santa Barbara.
W. B. Kern, M. D., Los Angeles.
Daniel D. Lustig, M. D., San Francisco.
James H. McBride, M. D., Pasadena.
Frank M. Mikels, M. D., Long Beach.
Eva C. Reid, M. D., San Francisco.
Elmer E. Stone, M. D., San Francisco.
Alonzo P. Williamson, M. D., Santa Monica.
Harold W. Wright, M. D., San Francisco.

COLORADO—Colorado State Home and Training School for Mental Defectives, Ridge.
A. P. Busey, M. D., Superintendent.

Colorado State Insane Asylum, Pueblo.
Howard A. La Moure, M. D., Superintendent.
Alton L. Smiley, Assistant Physician.

Mount Airy Sanatorium, Denver.
George E. Neuhaus, M. D., Superintendent.

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COLORADO—*Continued.*

WOODCROFT HOSPITAL, PUEBLO.
Hubert Work, M. D., Superintendent.
Chas. W. Thompson, Assistant Superintendent.
Philip Work, M. D., Assistant Physician.

Wm. P. Hunnicutt, M. D., Pueblo.
Wm. D. Runyan, M. D., Colorado Springs.
Frank T. Stevens, M. D., Colorado Springs.

CONNECTICUT—CONNECTICUT HOSPITAL FOR THE INSANE, MIDDLETOWN.
C. Floyd Haviland, M. D., Superintendent.
Wm. C. Sandy, M. D., Assistant Superintendent.
Charles E. Stanley, M. D., Assistant Physician.
Louis R. Brown, M. D., Assistant Physician.
Hamilton Rinde, M. D., Assistant Physician.
Edward T. Gibson, M. D., Assistant Physician.

CONNECTICUT COLONY FOR EPILEPTICS, MANSFIELD DEPOT.
John F. Hackett, M. D., Assistant Physician.

CONNECTICUT SCHOOL FOR IMBECILES, LAKEVILLE.
No members.

DR. GIVENS' SANITARIUM, STAMFORD.
Amos J. Givens, M. D., Proprietor.

DR. RULAND'S SANITARIUM, WESTPORT.
Frederick D. Ruland, M. D., Proprietor.

DR. WADSWORTH'S SANITARIUM, SOUTH NORWALK.
No members.

HOSPITAL FOR THE INSANE, NORWICH.
Henry M. Pollock, M. D., Superintendent.

MANSFIELD STATE TRAINING SCHOOL AND HOSPITAL, MANSFIELD, DEPOT.
Chas. T. La Moure, M. D., Superintendent.
Gilbert T. Smith, M. D., Assistant Physician.

THE HARTFORD RETREAT, HARTFORD.
Whitefield N. Thompson, M. D., Superintendent.

WESTPORT SANATORIUM, WESTPORT.
Emanuel S. Brodsky, Assistant Superintendent.

C. C. Burlingame, M. D., South Manchester.
Arthur B. Coleburn, M. D., Capt. M. R. C., U. S. Army.
Allen Ross Diefendorf, M. D., New Haven.
Charles W. Page, M. D., Hartford.
Edwin Everett Smith, M. D., Kensett, Norwalk.
Paul Waterman, M. D., Major M. R. C., U. S. Army.

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D

DELAWARE—Delaware State Hospital, Farnhurst.
W. H. Hancker, M. D., Superintendent.

Harris M. Carey, M. D., Odessa.

DISTRICT OF COLUMBIA—St. Elizabeth Hospital, Washington.
William A. White, M. D., Superintendent.
Shepherd I. Franz, A. B., Ph. D., M. D., LL. D., Scientific Director.
Edward J. Kempf, A. B., M. D., Clinical Psychiatrist.
Mary O'Malley, M. D., Senior Assistant Physician.
Alfred Glascock, M. D., Senior Assistant Physician.
James C. Hassall, M. D., Senior Assistant Physician.
John E. Lind, M. D., Senior Assistant Physician.
J. A. F. Pfeiffer, M. D., Senior Assistant Physician.
Arrah B. Evarts, M. D., Assistant Physician.
Ross McC. Chapman, M. D., Assistant Physician.
Mildred E. Scheetz, M. D., Assistant Physician.

D. Percy Hickling, M. D., Washington.
Benjamin R. Logie, M. D., Washington.
J. C. Simpson, M. D., Washington.
Tom A. Williams, M. D., Washington.

F

FLORIDA—Asylum for Indigent Insane, Chattahoochee.
No members.

Charles A. Barlow, M. D., Tampa.
Ralph N. Greene, M. D., 438 St. James Bldg., Jacksonville.
H. C. Kehoe, M. D., Ft. Myers, Fla.
James H. Randolph, M. D., Jacksonville.

G

GEORGIA—Invalids' Home, Milledgeville.
Henry D. Allen, M. D., Superintendent.
Wm. A. Ellison, M. D., Assistant Physician.
State Sanitarium, Milledgeville.
L. M. Jones, M. D., Superintendent.
John W. Mobley, M. D., Assistant Physician.
Y. H. Yarbrough, M. D., Assistant Physician.
N. P. Walker, M. D., Assistant Physician.
Bernard McHugh Cline, Assistant Physician.

Hansell Crenshaw, M. D., Atlanta.
Lewis M. Gaines, M. D., Atlanta.
Cheston King, M. D., Atlanta.

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I

IDAHO—Idaho Insane Hospital, Blackfoot.
No members.
Idaho Northern Insane Asylum, Orofino.
John W. Givens, M. D., Superintendent.

ILLINOIS—Alton State Hospital, Alton.
Geo. A. Zeller, M. D., Managing Officer.
Anna State Hospital, Anna.
No members.
Chester State Hospital, Menard.
No members.
Chicago State Hospital, Dunning.
Chas. F. Read, M. D., Managing Officer.
Dixon State Colony, Dixon.
Henry B. Carriel, M. D., Managing Officer.
Elgin State Hospital, Elgin.
Ralph T. Hinton, M. D., Managing Officer.
R. M. Ritchie, M. D., Assistant Physician.
Jacksonville State Hospital, Jacksonville.
Wilma H. Jacobs, M. D., Assistant Physician.
Juvenile Psychopathic Institute, Chicago.
Herman Adler, M. D., Director.
Kankakee State Hospital, Hospital.
Eugene Cohn, M. D., Managing Officer.
H. Douglas Singer, M. D., Director State Psychopathic Institute.
F. J. Sullivan, M. D., Assistant Physician.
Drury L. Fish, M. D., Assistant Physician.
J. T. Rooks, M. D., Assistant Physician.
Walter A. Ford, M. D., Assistant Physician.
Thos. J. Riarch, M. D., Assistant Physician. M. R. C., U. S. Army.
Howard T. Child, M. D., Pathologist.
Kenilworth Sanitarium, Kenilworth.
Sanger Brown, M. D., Chief of Medical Staff.
Sherman Brown, M. D., Superintendent.
Lincoln State School and Colony, Lincoln.
Charles R. Lowe, M. D., Assistant Physician.
Norbury Sanatorium, Jacksonville.
Frank P. Norbury, M. D., Medical Director.
Peoria State Hospital, Peoria.
No members.
State Epileptic Colony, Dixon.
No members.
State Psychopathic Institute, Kankakee.
Charles Rickaher, M. D., Pathologist. U. S. Army.

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ILLINOIS—*Continued.*

THE RANSOM SANITARIUM, ROCKFORD.
Sidney D. Wilgus, M. D., Superintendent and Proprietor.

WATERTOWN STATE HOSPITAL, WATERTOWN.
M. C. Hawley, M. D., Managing Officer.
Edward Foley, M. D., Assistant Physician.

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Wm. A. Crooks, M. D., Rock Island, Ill.
H. J. Gahagan, M. D., Chicago.
Edward F. Leonard, M. D., Chicago.
Harry S. Seiwell, M. D., M. R. C., U. S. Army.
Stephen R. Pietrowicz, M. D., Chicago.
Mary E. Pogue, M. D., Wheaton.
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INDIANA—CENTRAL INDIANA HOSPITAL FOR THE INSANE, INDIANAPOLIS.
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Frederick C. Potter, M. D., Pathologist.

EASTERN INDIANA HOSPITAL FOR THE INSANE, RICHMOND.
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Joseph S. Craig, M. D., Assistant Physician. M. R. C., U. S. Army.
Mary Wickers, Woman Physician.

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NORTHERN INDIANA HOSPITAL FOR THE INSANE, LONGCLIFF, LOGANSPORT.
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Lorne W. Yule, M. D., Assistant Physician.
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Mary Violet Church, M. D., Assistant Physician.

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CLARINDA STATE HOSPITAL, CLARINDA.
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T. L. Long, M. D., Assistant Physician.
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K

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L

LOUISIANA—EAST LOUISIANA HOSPITAL FOR THE INSANE, JACKSON.
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Charles V. Unsworth, M. D., New Orleans.
Roy McLean VanWart, M. D., New Orleans. M. R. C., U. S. Army.

M

MAINE—AUGUSTA STATE HOSPITAL, AUGUSTA.
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Karl B. Sturgis, M. D., Assistant Physician.
BANGOR STATE HOSPITAL, BANGOR.
Pearl Tenny Haskell, M. D., Superintendent.
MAINE SCHOOL FOR FEEBLE-MINDED, WEST POWNAL.
Carl J. Hedin, M. D., Superintendent.
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Frederick L. Hills, M. D., Bangor.
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No members.

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L. Gibbons Smart, M. D., Medical Superintendent.

Crownsville State Hospital, Crownsville.
Robt. P. Winterode, M. D., Superintendent.

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Charles J. Carey, M. D., Superintendent.

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Adolf Meyer, M. D., Director.
Charles Macfie Campbell, M. D., Assistant Director.

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Lewis H. Gundry, M. D., Superintendent.

Riggs Cottage-Sanitarium, Ijamsville.
George Henry Riggs, M. D., Superintendent.

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Frank W. Keating, M. D., Superintendent.

Rosewood State Training School, Owings Mills.
Kenneth B. Jones, M. D., Physician.

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George B. Wolff, M. D., Assistant Physician.

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R. Edward Garrett, M. D., Assistant Physician.

Springfield State Hospital, Sykesville.
Joseph Clement Clark, M. D., Superintendent.
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A. T. Gundry, M. D., Medical Director.

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Cornelius DeWeese, M. D., Medical Director.

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Richard F. Gundry, M. D., Medical Director and Proprietor.

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S. J. Fort, M. D., Baltimore.
Andrew C. Gillis, M. D., Baltimore.
Arthur P. Herring, M. D., Baltimore.
Henry M. Hurd, M. D., Baltimore.
J. A. MacIntosh, M. D., Easton.
J. G. Fowble Smith, Brunswick.
Irving J. Spear, M. D., Baltimore.
Hugh Hampton Young, M. D., Baltimore.

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Florence Hale Abbot, M. D., Assistant Physician.
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Anna C. Wellington, M. D., Assistant Physician.
Harry C. Solomon, M. D., Assistant Physician.
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Myrtelle M. Canavan, M. D., Pathologist.

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Geo. H. Torney, Jr., M. D., Associate Physician.

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CHANNING SANITARIUM, BROOKLINE.
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Marion E. Kenworthy, M. D., Assistant Physician, Foxborough.

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Harlan L. Paine, M. D., Assistant Superintendent.

GRAFTON STATE HOSPITAL, WORCESTER.
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Geo. K. Butterfield, M. D., Assistant Physician.
Douglas A. Thom, M. D., Assistant Physician.
Wm. A. MacIntyre, M. D., Assistant Physician.
Arthur E. Pattrell, M. D., Assistant Physician.
Michael J. O'Meara, M. D., Assistant Physician.

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H. Louis Stick, M. D., Superintendent.

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MASSACHUSETTS GENERAL HOSPITAL.
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Ray L. Whitney, M. D., Assistant Physician.
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Walter J. Otis, M. D., Assistant Physician.

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Geo. Allen Troxell, M. D., Assistant Physician.
Walter Burrier, M. D., Assistant Physician.

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MONSON STATE HOSPITAL, PALMER.
Everett Flood, M. D., Superintendent.
Morgan B. Hodskin, M. D., Assistant Physician.

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John H. Nichols, M. D., Superintendent.

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Horace G. Ripley, M. D., Assistant Superintendent
John F. O'Brien, M. D., Assistant Physician.

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M. M. Jordan, M. D., Assistant Physician.
Dana Fletcher Downing, M. D., Assistant Physician.

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Edward H. Wiswall, M. D., Proprietor.

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Mary E. Morse, M. D.
B. Henry Mason, M. D., Assistant Physician.
Harold I. Goaline, M. D., Assistant Physician.
Donald R. Gillfillan, M. D., Assistant Physician.

L. Vernon Briggs, M. D., Boston. U. S. Army.
Isador H. Coriat, M. D., Boston.
Edward Cowles, M. D., Plymouth.
Samuel W. Crittenden, M. D., Boston.
Charles G. Dewey, M. D., Dorchester.
J. F. Edgerley, M. D., Lincoln.
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Christine Leonard, M. D., Boston.
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Frank S. Bachelder, Assistant Superintendent.

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Guy L. Connor, M. D., Detroit.
Charles W. Hitchcock, M. D., Detroit.
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William A. Stone, M. D., Kalamazoo.
Wesley Taylor, M. D., Detroit.

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Clara Eirley, M. D., Woman Physician.

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Charles R. Ball, M. D., St. Paul.
Edward J. Engberg, M. D., St. Paul.
Arthur S. Hamilton, M. D., Minneapolis.
Ernest M. Hammes, M. D., St. Paul.
Wm. A. Jones, M. D., Minneapolis.
Angus W. Morrison, M. D., St. Paul.
C. Eugene Riggs, M. D., St. Paul.

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STATE INSANE HOSPITAL, ASYLUM P. O.
W. W. Smithson, M. D., Superintendent.

STATE INSANE HOSPITAL, JACKSON.
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Herbert Lee, M. D., Resident Physician.
Thompson P. Scott, M. D., Assistant Physician.

GLENWOOD SANITARIUM, ST. LOUIS.
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No members.

STATE HOSPITAL NO. 2, ST. JOSEPH.
No members.

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THE PUNTON SANITARIUM, KANSAS CITY.
G. Wilse Robinson, M. D., Superintendent.

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Charles G. Chaddock, M. D., St. Louis.
William F. Kuhn, M. D., Kansas City.
Abra C. Pettijohn, M. D., Brookfield.
A. L. Skoog, M. D., Kansas City.

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A. Burton Eckerdt, M. D., Assistant Physician.

Arthur C. Knight, M. D., Butte.
Rose A. Russell, M. D., Ft. Shaw.

N

NEBRASKA—NEBRASKA HOSPITAL FOR INSANE, LINCOLN.
Halle L. Ewing, M. D., Assistant Physician.

NEBRASKA INSTITUTION FOR FEEBLE-MINDED, BEATRICE.
No members.

NEBRASKA STATE HOSPITAL, INGLESIDE.
No members.

NORFOLK HOSPITAL FOR THE INSANE, NORFOLK.
No members.

B. F. Williams, M. D., Lincoln.

NEVADA—NEVADA HOSPITAL FOR MENTAL DISEASES, RENO.
No members.

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NEW HAMPSHIRE STATE HOSPITAL, CONCORD.
Charles H. Dolloff, M. D., Superintendent.

STATE SCHOOL FOR FEEBLE-MINDED CHILDREN, LACONIA.
Benjamin W. Baker, M. D., Superintendent.

Chas. P. Bancroft, M. D., Concord.

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George Bancroft Gale, M. D., Medical Director.

Bancroft School for Feeble-Minded Youth, Haddonfield.
E. A. Farrington, M. D., Physician.

Belle Mead Farm Colony and Sanatorium, Belle Mead.
J. J. Kindred, M. D., Proprietor and Consulting Physician.
William E. Gesregen, M. D., Resident Physician.

Burlington County Hospital for Insane, Mt. Holly.
No members.

Camden County Hospital for Insane, Blackwood.
J. Anson Smith, M. D., Physician.

Essex County Hospital for the Insane, Cedar Grove, Essex County.
Guy Payne, M. D., Medical Superintendent.
Earl H. Snavely, M. D., Assistant Physician.
George W. Davies, M. D., Assistant Physician.
Helene G. Leehman, M. D., Assistant Physician.
Henry G. Smith, M. D., Assistant Physician.

Fair Oaks Sanitarium, Summit.
Thomas P. Prout, M. D.

Hudson County Hospital for Insane, Secaucus, Jersey City.
H. V. A. Smith, M. D., Superintendent.
George W. King, M. D., Medical Director.

Morristown Memorial Hospital, Morristown.
Geo. B. Landers, M. D., Superintendent.

New Jersey State Hospital, Morris Plains.
B. D. Evans, M. D., Medical Director.
E. Moore Fisher, M. D., Senior Assistant Physician.
Marcus A. Curry, M. D., Assistant Physician.
John V. Donnet, M. D., Assistant Physician.
Frederic H. Thorne, M. D., Pathologist.

New Jersey State Hospital, Trenton.
Henry A. Cotton, M. D., Medical Director.
John C. Felty, M. D., Assistant Physician.
P. B. Means, M. D., Assistant Physician.
Edgar B. Funkhouser, M. D., Second Assistant Physician.
Harry D. Williams, M. D., Assistant Physician.
R. G. Barry, M. D., Assistant Physician.
W. W. Stevenson, M. D., Assistant Physician.
R. P. Truitt, M. D., Assistant Physician.

New Jersey State Village for Epileptics, Skillman.
David F. Weeks, M. D., Superintendent.

North Hudson Hospital, Jersey City.
John Nevin, M. D., Consulting Physician.

"Riverlawn" Sanitarium, Paterson.
Daniel T. Millspaugh, M. D., Superintendent.

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Percy Bryant, M. D., Rahway.
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J. Henry Clark, M. D., Newark.
Paul Lange Cort, M. D., Trenton.
Luther M. Halsey, M. D., Williamstown.
Frederick S. Hammond, M. D., Atlantic Highlands.
Arthur P. Hasking, M. D., Jersey City.
L. S. Hinckley, M. D., Newark.
William E. Ramsey, M. D., Perth Amboy.
Louis K. Henschel, M. D., U. S. Army.

NEW MEXICO—New Mexico Insane Asylum, Las Vegas.
No members.

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Edward Gillespie, M. D., Senior Assistant Physician.
Wm. J. Tiffany, M. D., Senior Assistant Physician.
Eloise Walker, M. D., Woman Physician.
C. H. Bellinger, M. D., Assistant Physician.

Bloomingdale Hospital, White Plains.
William L. Russell, M. D., Superintendent.
George S. Amsden, M. D., Assistant Physician.
Carl Murdock Bowman, M. D., Assistant Physician.
Chas. I. Lambert, M. D., Assistant Physician.

Brooklyn State Hospital, Brooklyn.
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Erving Holley, M. D., Assistant Physician.
Joseph Smith, M. D., Assistant Physician.
Donald L. Ross, M. D., Assistant Physician.

Breezehurst Terrace, Whitestone, L. I.
Daniel A. Harrison, M. D., Resident Physician.

Brigham Hall, Canandaigua.
Robert G. Cook, M. D., Resident Physician.

Brunswick Home, Amityville.
Convas L. Markham, M. D., Superintendent.

Buffalo State Hospital, Buffalo.
Arthur W. Hurd, M. D., Superintendent.
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Joseph B. Betts, M. D., Senior Assistant Physician.
George G. Armstrong, M. D., Senior Assistant Physician.
Helene J. C. Kuhlman, M. D., Assistant Physician.
Robert King, M. D., Senior Assistant Physician.
Christopher Fletcher, M. D., Senior Assistant Physician.
Herman F. May, M. D., Assistant Physician.
Cyrus E. Pringle, M. D., Assistant Physician.

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David Corcoran, M. D., Senior Assistant Physician.
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V

VERMONT—Brattleboro Retreat, Brattleboro.
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Herbert W. Taylor, M. D., First Assistant Physician.

State Hospital for the Insane, Waterbury.
Frederick L. Hills, M. D., Pittsford.

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VIRGINIA—CENTRAL STATE HOSPITAL, PETERSBURG.
William F. Drewry, M. D., Superintendent.
Hugh Carter Henry, M. D., First Assistant Physician.
EASTERN STATE HOSPITAL, WILLIAMSBURG.
G. W. Brown, M. D., Superintendent.
G. G. Hawkins, M. D., First Assistant Physician.
Susan Price, M. D., Assistant Physician.
SOUTHWESTERN STATE HOSPITAL, MARION.
Estelle H. Henderson, M. D., Superintendent.
STATE EPILEPTIC COLONY, MADISON HEIGHTS.
A. S. Priddy, M. D., Superintendent.
ST. ALBANS SANITARIUM, RADFORD.
John C. King, M. D., Resident Physician.
WEST BROOK SANATORIUM, RICHMOND.
Paul V. Anderson, M. D., Resident Physician.
Jas. K. Hall, M. D., Resident Physician.
WESTERN STATE HOSPITAL, STAUNTON.
J. S. De Jarnette, M. D., Superintendent.
J. H. Garlick, M. D., Assistant Physician.

Oliver C. Brunk, M. D., Richmond.

W

WASHINGTON—EASTERN WASHINGTON HOSPITAL FOR THE INSANE, MEDICAL LAKE.
John M. Semple, M. D., Superintendent.
NORTHERN HOSPITAL FOR INSANE, SEDRO WOOLLEY.
No members.
STATE INSTITUTION FOR FEEBLE-MINDED, MEDICAL LAKE.
No members.
WESTERN WASHINGTON HOSPITAL FOR THE INSANE, FORT STEILACOOM.
No members.

Robert P. Smith, M. D., Seattle.

WEST VIRGINIA—HUNTINGTON STATE HOSPITAL, HUNTINGTON.
L. V. Guthrie, M. D., Superintendent.
Harry W. Keatley, M. D., Assistant Physician. M. R. C., U. S. Army.
SPENCER STATE HOSPITAL, SPENCER.
No members.
WEST VIRGINIA HOSPITAL FOR THE INSANE AT WESTON.
No members.

Ray M. Babbitt, M. D., Huntington.
James R. Bloss, M. D., Huntington. U. S. Army.
Chas. W. Halterman, M. D., Weston.

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WISCONSIN—Lake Geneva Sanitarium, Lake Geneva.
No members.

Milwaukee Asylum for the Chronic Insane, Wauwatosa.
William F. Beutler, M. D., Superintendent.

Milwaukee Hospital for the Insane, Wauwatosa.
A. F. Young, M. D., Superintendent.

Milwaukee Sanitarium, Wauwatosa.
Richard Dewey, M. D., Physician-in-Charge.
Herbert Wm. Powers, M. D.

Northern Hospital for the Insane, Winnebago.
Adin Sherman, M. D., Superintendent.

Oak Leigh Sanitarium, Lake Geneva.
No members.

Oconomawoc Health Resort, Oconomawoc.
Arthur W. Rogers, M. D., Superintendent.

Palmyra Sanitarium, Palmyra.
No members.

The Sanatorium, Hudson.
W. H. Darling, M. D., Superintendent.

Waukesha Springs Sanitarium, Waukesha.
Byron M. Caples, M. D., Superintendent.

Wisconsin Home for Feeble-Minded, Chippewa Falls.
No members.

Wisconsin State Hospital for Criminal Insane, Waupun.
No members.

Wisconsin State Hospital for the Insane, Mendota.
William F. Lorenz, M. D., First Assistant Physician.

William F. Becker, M. D., Milwaukee.
Anne Burnet, M. D., Wausau.
John B. Edwards, M. D., Milwaukee.
Roy E. Mitchell, M. D., Eau Claire.
Charles Gorst, M. D., Mendota.
S. S. Stack, M. D., Milwaukee.
J. F. Wen Glesky, M. D., Milwaukee.
M. J. White, M. D., Milwaukee.

WYOMING—State Hospital for the Insane, Evanston.
Charles H. Solier, M. D., Superintendent.

BRITISH AMERICA.

BRITISH COLUMBIA—Public Hospital for Insane, New Westminster
Charles Edward Doherty, M. D., Superintendent.
James G. McKay, M. D., Assistant Physician.

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MANITOBA—Asylum for the Insane, Selkirk.
H. C. Norquay, M. D., Assistant Superintendent.
Brandon Asylum, Brandon.
H. E. Hicks, M. D., Assistant Physician.

David Young, M. D., Winnipeg.

NEW BRUNSWICK—The Provincial Hospital, St. John.
James V. Anglin, M. D., Superintendent.

NEWFOUNDLAND—Asylum for the Insane, St. John's.
No members.

NOVA SCOTIA—Nova Scotia Hospital, Halifax.
Frederick E. Lawlor, M. D., Superintendent.

W. H. Hattie, M. D., Halifax.

ONTARIO—Asylum for the Insane, Cobourg.
No members.

Asylum for the Insane, London.
W. J. Robinson, M. D., Superintendent.

Asylum for the Insane, Penetanguishene.
William T. Wilson, M. D., Superintendent

Homewood Sanitarium, Guelph.
Alfred T. Hobbs, M. D., Superintendent.
E. C. Barnes, M. D., Assistant Physician.

Hospital for the Insane, Brockville.
John C. Mitchell, M. D., Superintendent.

Hospital for the Insane, Hamilton.
W. M. English, M. D., Superintendent.
Peter MacNaughton, M. D., Assistant Superintendent

Hospital for the Insane, Toronto.
James M. Forster, M. D., Superintendent.

Mimico Hospital for the Insane, Toronto.
Nelson H. Beemer, M. D., Superintendent.

Rockwood Hospital for the Insane, Kingston.
Edward Ryan, M. D., Superintendent.
Ernest H. Young, M. D., Assistant Superintendent.

Simcoe Hall, Barrie.
W. C. Barber, M. D., Superintendent.

Toronto General Hospital, Toronto.
Charles K. Clarke, M. D., Medical Superintendent.

Jno. G. Fitzgerald, M. D., Toronto.

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PRINCE EDWARD ISLAND—FALCONWOOD HOSPITAL FOR INSANE, CHARLOTTETOWN.

No members.

V. L. Goodwill, M. D., Charlottetown.

QUEBEC—BEAUPORT ASYLUM FOR THE INSANE, BEAUPORT, QUEBEC.

M. D. Brochu, M. D., Superintendent.

PROTESTANT HOSPITAL FOR THE INSANE, MONTREAL.

T. J. W. Burgess, M. D., Superintendent.
Carlyle A. Porteous, M. D., Assistant Superintendent.
Andrew Macphail, M. D., Consulting Pathologist.
David Alexander Shirres, M. D., Consulting Neurologist.
Hedley V. Robinson, M. D., Assistant Physician.
Robt. C. Hiscock, M. D., Assistant Physician.
J. F. Leigh Brown, M. D., Assistant Physician.

E. Philippe Chagnon, M. D., Montreal.
Haig A. Sims, M. D., Montreal.

SAINT JEAN DE DIEU HOSPITAL, MONTREAL.

Francis E. Devlin, M. D., Assistant Superintendent.

SASKATCHEWAN.

James W. McNeill, M. D., Battleford.

CUBA—MALBERTI'S SANITARIUM, HAVANA.

José A. Malberti, M. D., Physician-in-Charge.

HAWAII.

Wm. A. Boyd, M. D., Schofield Barracks.

PORTO RICO—INSANE ASYLUM, SAN JUAN.

No members.

PHILIPPINE ISLANDS.

A. P. Goff, M. D., Manilla.

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AMERICAN MEDICO-PSYCHOLOGICAL ASSOCIATION.

CONSTITUTION.

ARTICLE I.

This organization shall be known as the AMERICAN MEDICO-PSYCHOLOGICAL ASSOCIATION, this name being adopted in 1892 by "The Association of Medical Superintendents of American Institutions for the Insane," founded in 1844.

ARTICLE II.

The object of this Association shall be the study of all subjects pertaining to mental disease, including the care, treatment, and promotion of the best interests of the insane.

ARTICLE III.

There shall be five classes of members: (1) Active members, who shall be physicians, resident in the United States and British America, especially interested in the treatment of insanity; (2) Associate members; (3) Life members; (4) Honorary members; and (5) Corresponding members.

ARTICLE IV.

The officers of the Association shall consist of a President, Vice-President, Secretary—who shall also be the Treasurer—three Auditors, and twelve other members of the Association to be called Councilors; all of these officers together shall constitute a body which shall be known as the Council.

NOTE.—The Association of Medical Superintendents of American Institutions for the Insane was founded in 1844 by the original thirteen members. In 1891, when its membership had increased to more than two hundred, it was proposed, at the annual meeting of that year in Washington, to form a better organization of the Association—its work having previously been done under the somewhat unstable rules of custom and a few resolutions scattered through its records. The proposition was agreed to, and at the annual meeting in Washington, in 1892, there were unanimously adopted the following Constitution and By-Laws, with the change of name to the AMERICAN MEDICO-PSYCHOLOGICAL ASSOCIATION.

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ARTICLE V.

The Active members of the Association shall include all past and present medical superintendents named in the official list published for 1892 of members of "The Association of Medical Superintendents of American Institutions for the Insane"; the Life members shall be such Active members as shall have been members of the Association for a consecutive period of thirty (30) years; the Honorary members shall include those so designated in that list; the Associate members shall include all the assistant physicians named in the same list; it being provided that said list shall be corrected by the Council, as may be necessary to carry out the intention of the Constitution as to the continuance of existing membership.

Every candidate for admission to the Association hereafter as an Active member shall be proposed to the Council, in writing, in an application addressed to the President, at any annual meeting preceding the one at which the election is held. Honorary, Associate, or Corresponding members shall be proposed to the Council, in writing, in an application addressed to the President, at least two months prior to the meeting of the Association. Every application of whatever class must include a statement of the candidate's name and residence, professional qualifications, and any appointments then or formerly held, and certifying that he is a fit and proper person for membership. In the case of a candidate for Active or Associate membership, the application shall be signed by three Active members of the Association; and by six Active members for the proposal of an Honorary or Corresponding member. The names of all candidates approved by a majority vote of members of the Council present at its annual meeting shall be presented on a written or printed ballot to the Association at its concurrent annual meeting, at least one session previous to that at which the election is made, which shall be by ballot at a regular session, and require a majority vote of the members present. Physicians who, by their professional work or published writings, have shown a special interest in the care and welfare of the insane, are eligible to Active membership. The only persons eligible for Associate membership are regularly appointed assistant physicians of institutions for the insane that are regarded to be properly such by the Council; and they are

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eligible for such membership only during the time they are holding such appointments. After holding such an appointment three years, an Associate member may become an Active member by making application, in writing, to the Council, and upon its approval, being elected in the manner heretofore prescribed.

ARTICLE VI.

Physicians and others who have distinguished themselves by their attainments in branches of science connected with insanity, or who have rendered signal service in philanthropic efforts to promote the interests of the insane, shall be eligible for Honorary membership.

Physicians not residents in the United States and British America, who are actively engaged in the treatment of insanity, may be elected Corresponding members.

Active members only shall be entitled to a vote at any meeting, or be eligible to any office. Life, Honorary and Corresponding members shall be exempt from all payments of annual dues to the Association.

ARTICLE VII.

Any member of the Association may withdraw from it on signifying his desire to do so in writing to the Secretary: *Provided,* That he shall have paid all his dues to the Association. Any member who shall fail for three successive years to pay his dues after special notice by the Treasurer shall be regarded as having resigned his membership, unless such dues shall have been remitted by the Council for good and sufficient reasons.

Any member who shall be declared unfit for membership by a two-thirds vote of the members of the Council present at an annual meeting of that body shall have his name presented by it for the action of the Association from which he shall be dismissed if it be so voted by two-thirds of the members present at its annual meeting.

ARTICLE VIII.

The Officers and Councilors shall be elected at each annual meeting. They shall be nominated to the Association on the second day of the annual meeting in the order of business of the first session of that day, by a committee appointed for that pur-

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pose by the President; and the election shall take place immediately. The election shall be made as the meeting may determine, and the person who shall have received the highest number of votes shall be declared elected to the office for which he has been nominated.

The President, Vice-President, the Secretary and Treasurer, and Auditors shall hold office for one year or until the beginning of the term for which their successors are elected. One Auditor shall be elected for one year, one for two years, and one for three years. The Secretary and Treasurer and one Auditor are eligible for re-election. At the first election of Councilors, four members shall be elected for one year, four for two years, and four for three years; and thereafter four members shall be elected each year to hold office three years, or until their successors are elected. The President, Vice-President, one Auditor, and the four retiring Councilors are ineligible for re-election to their respective offices for one year immediately following their retirement. All the officers and Councilors shall enter upon their duties immediately after their election, excepting the President and Vice-President. When any vacancies occur in any of the offices of the Association, they shall be filled by the Council until the next annual meeting.

A quorum of the Council shall be formed by six members; and of the Association by twenty Active members.

Article IX.

The President and Vice-President for the year shall enter on their duties at the close of the business of the annual meeting at which they are elected. The President shall prepare an inaugural address to be delivered at the opening session of the meeting. He shall preside at all the annual or special meetings of the Association or Council, or in his absence at any time, the Vice-President shall act in his place.

The Secretary and Treasurer shall keep the records of the Association and perform all the duties usually pertaining to that office, and such other duties as may be prescribed for him by the Council; and under the same authority he shall receive and disburse and duly account for all sums of money belonging to the Association. He shall keep accurate accounts and vouchers of all his receipts and payments on behalf of the Association, and of

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all invested funds, with the income and disposition thereof, that may be placed in his keeping, and shall submit these accounts, with a financial report for the preceding year, to the Council at its annual meeting. Each annual statement shall be examined by the Auditors, who shall prepare and present at each annual meeting of the Association a report showing its financial condition. The Council shall have charge of any funds in the possession of the Association, and which shall be invested under its direction and control. The Council shall keep a careful record of its proceedings, and make an annual report to the Association of matters of general interest. The Council shall also print annually the proceedings of the meetings of the Association and the reports of the Treasurer and Auditors.

The Council is empowered to manage all the affairs of the Association, subject to the Constitution and By-Laws; to appoint committees from the membership of the Association, and spend money out of its surplus funds for special scientific investigations in matters pertaining to the objects of the Association, to publish reports of such scientific investigations; to apply the income of special funds, at its discretion, to the purposes for which they were intended. The Council may also engage in the regular publication of reports, papers, transactions, and other matters, in annual volume, or in a journal, in such manner and at such times as the Council may determine, with the approval of the Association.

Article X.

Amendments to the Constitution and By-Laws shall be taken up for consideration at the first session of the second day of any annual meeting, and may be made by a two-thirds vote of all the members present: *Provided,* That notice of such proposed amendments be given in writing at the annual meeting next preceding. It shall be the duty of the Secretary to send to all the members a copy of any proposed amendment at least three months previous to the meeting when the action is to be taken.

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BY-LAWS.

Article I.

The meetings of the Association shall be held annually. The time and place of each meeting shall be named by the Council, and reported to the Association for its action at the preceding meeting. Each annual meeting shall be called by printed announcements sent to each member at least three months previous to the meeting.

The Council shall hold an annual meeting concurrent with the annual meeting of the Association; and the Council shall hold as many sessions and at such times as the business of the Association may require.

Special meetings of the Council may be called by the order of the Council. The President shall have authority at any time, at his own discretion, to instruct the Secretary to call a special meeting of the Council; and he shall be required to do so upon a request signed by six members of the Council. Such special meetings shall be called by giving at least four weeks' written notice.

Article II.

Each and every Active and Associate member shall pay an annual tax to the Treasurer, the amount to be fixed annually by the Council, not to exceed five dollars for an Active member, or two dollars for an Associate member.

Article III.

The order of business of each annual meeting of the Association shall be determined by the Council, and shall be printed for the use of the Association at its meeting. The Council shall also make all arrangements for the meetings of the Association, appointing such auxiliary committees from its own body, or from other members of the Association, and making such other provisions as shall be requisite, at its discretion.

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NOTE.

The accompanying volume, containing the proceedings, papers, and discussions of the American Medico-Psychological Association at its Seventy-third Annual Meeting, is printed by the Council with the approval of the Association.

HENRY C. EYMAN,
Secretary.

MASSILLON, OHIO,
March 1, 1918.

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AMERICAN MEDICO-PSYCHOLOGICAL ASSOCIATION.

PROCEEDINGS OF THE SEVENTY-THIRD ANNUAL MEETING.

NEW YORK, TUESDAY, MAY 29, 1917.
FIRST SESSION.

The Association convened at 10 a. m. in the north ball room of the Hotel Astor, New York, and was called to order by the President, Dr. Charles G. Wagner, Binghamton, N. Y.

THE PRESIDENT.—*Ladies and Gentlemen:* I have the honor to declare the seventy-third annual meeting of the American Medico-Psychological Association now in session. Its proceedings will be opened with prayer by the Rev. Anson P. Atterbury of New York.

The invocation was then offered by Rev. Dr. Atterbury.

THE PRESIDENT.—It is an exceedingly fortunate circumstance for our Association that this meeting happens to occur during an interval between the remarkable and enthusiastic demonstrations in New York City in honor of our distinguished visitors from England and France and others who are to come from Italy and Russia in the near future. We are, indeed favored this morning in having with us His Honor, the Mayor of New York, who has kindly consented to come here to bid us welcome to this great city. The Mayor is a busy man; his time is called for in many directions to meet the great business of his office and it is a high compliment to us that he has taken the time to come here for this occasion. I have very great pleasure in introducing the Honorable John Purroy Mitchel, Mayor of New York.

MAYOR MITCHEL.—*Mr. President, Ladies and Gentlemen of the American Medico-Psychological Association:* The city of New York, through me, extends a very cordial welcome to members of this Association. This city is always glad when a great association, representative of a profession or a business contributing to our social or our commercial life selects this city as the site for its annual convention. It is particularly appreciative that this Association, on the seventy-third occasion of its annual gathering, representing, as it does, a part of perhaps the greatest of all professions which has contributed so tremendously to the welfare of mankind should have chosen this city as the site for this meeting. Usually we attempt to point out those things within the field of the city's municipal effort, that may be of direct interest to the associations which choose the city as their

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meeting place. In this instance we are not able, perhaps, to point to institutions devoted to the study and the care of the insane since the state has taken over for the most part the care of the insane. Yet, the city still has jurisdiction over one group which I think might come within the purview of your work; I refer to the mental defectives as distinguished from the insane.

When the present administration assumed office here in New York there existed on Randall's Island an institution devoted to the so-called care of the feeble-minded. When we came to study the actual conditions in that institution, which was committed to the care of the Department of Charities, we found that not alone the neglect of the scientific side of the work of the institution but the neglect in the matter of mere physical care was such as to constitute of that institution a reproach to any civilized community.

The department undertook a study. After much effort and very considerable and powerful opposition, the incompetent superintendent of that institution was removed, a new superintendent appointed, a plan was laid down for the reconstruction of the entire physical plan and a new method of administration devised. The city of New York has appropriated up to the present time, measured by the period of this administration, $1,600,000 for the rebuilding of this institution on Randall's Island. It has invited the best advice that it could obtain in the United States. The new institution is being constructed under the general supervision of Dr. Fernald than whom I deem there is no greater authority in this country; and we feel that when the work which has already been initiated has been completed we will be able to point here in the city to the best administered and best equipped institution for the care of the feeble-minded in the country.

The change in the point of view of the city toward the feeble-minded children, the change in the character of the care that these helpless wards of the community have received and are now receiving is merely illustrative of the change in the point of view and in the method of treatment of the insane that has taken place during the past half century; from treatment which regarded them practically as social outcasts, as people almost beyond the purview of the law, they have come to be regarded as sick and the treatment which is now being accorded to these unfortunates is based upon scientific research and upon scientific principles. To that result, Mr. President, I understand that the members of this Association have contributed in a very large degree. For that result the community owes to your profession and to your Association its appreciation and its thanks; and it is to that acknowledgment as well as to the appreciation individually of the members of this Association and of your profession that I have come to testify on behalf of the city of New York and to bid you a most cordial welcome. (Applause.)

THE PRESIDENT.—It is indeed most gratifying to find that a public official in so great an office as that of Mayor of the city of New York can find time to study in detail the great problem of the scientific care of the mentally

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defective. Mayor Mitchel has given us ample evidence in the address to which we have listened, not only of his profound knowledge of this subject but of his great interest in the welfare of an unfortunate class of human beings. I am sure that I voice the sentiments of this Association in extending to the Mayor our heartfelt thanks for his able address and his cordial welcome to New York. (Applause.)

We have with us on this occasion a distinguished physician, a representative of an old and honored organization, a physician who has attained eminence in this great city as a practitioner of medicine, as a consultant in many hospitals, as a teacher in the medical schools, and a man who is altogether a commanding figure in the profession. I have the honor of introducing Dr. Walter B. James, President of the New York Academy of Medicine. (Applause.)

Dr. James, in his address of welcome, said that it was unusual for him to address so analytical a gathering as a convention of psychiatrists. To be chosen to extend a greeting to the Association on the part of the medical profession of New York was not only a pleasure and an honor but an inspiration. He would not venture to speak in any way for the psychiatrists of the city as they would be represented by their own spokesman. It seemed to him that there had been few movements in the past half century fraught with such great possibilities of good to man as the development of modern psychiatry. Although the study of the abnormal mind went as far back as any study of any part of the human body, there seemed to him to be developing the beginning of an entirely new practice of this specialty; and possibly the explanation might be a better understanding on the part of the people at large. He would take the liberty of indulging in some mild criticism of a tendency of psychiatrists which also might be applied equally to all scientists, especially youthful scientists; this was to use long and complex words, obscure terms. He was pleased to note on the program a proposed discussion of plans designed to bring psychiatry more closely and intimately into the teaching of the medical schools; in his judgment there were many things taught in the medical curriculum that might much better give place to psychiatry. Certainly in his branch of medicine it was becoming realized that the highest development in internal medicine was absolutely impossible with a knowledge of psychiatry.

Dr. James stated that he was glad to substantiate Mayor Mitchel's claim that the charitable institutions of the city had been emancipated from political taint.

Finally it was a very great pleasure for him on behalf of the medical profession to offer to the members of the Association the warmest kind of welcome and to express the hope and belief that their deliberations might be productive of the very highest possible result. This he believed could be achieved in any community through proper awakening of the public spirit. (Applause.)

THE PRESIDENT.—Whether or not Dr. James' "number" on the program is viewed as a tenor solo as he has suggested, makes very little difference,

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I think, to us, if I may judge from the close attention you gave him during his address; certainly, the Association gave him ample evidence of its appreciation. His allusion to the multiplicity of terms in psychiatry that often becloud its meaning reminded me of a medico-legal case that occurred in this city some years ago in which one of the experts indulged in a great deal of medical terminology, so much so that after explaining his views repeatedly and at length, the court, the jury and everybody else seemed to be more or less hazy as to his meaning. Irvin Cobb, in reporting the testimony in one of the newspapers on the following day, facetiously alleged that at this point the attorney for the prosecution arose and addressing the court said, "Your Honor: Will you please instruct the witness to explain his testimony once more so that *nobody* will understand it?" (Laughter.) I am sure we are very grateful to Dr. James for his excellent address.

New York City may justly claim to be the home of the ablest neurologists in America. The professional men in this field, in this great city, have no superiors in the world. As teachers of medicine in our medical schools, as diagnosticians and practitioners in our hospitals, and as physicians in the community, they command the confidence and respect, not only of the people to whom they minister but of that much more critical world, the medical profession. Among the eminent men in this body none stands higher than the professor of mental and nervous diseases in the Cornell and Bellevue Hospital Medical Schools. I now have pleasure in introducing Dr. Chas. Loomis Dana, of New York.

Dr. Dana.—*Mr. President, Ladies and Gentlemen:* I hold no place in psychiatry which justifies me in being put into the limelight in this way. But, while not a member of this Association, I have followed and studied its work for a great many years and I have recognized its progress and its ever widening sphere of usefulness, and I welcome you gentlemen as fellow physicians now forming a band of workers very greatly essential to the health of the state and the progress of medicine. In my early days your Association was looked upon rather obliquely by neurologists, and some other critics, as one suffering from lack of progress; as one given over to the care of agriculture and administration rather than to medicine and science; as one in which the raising of potatoes and fighting politicians—two occupations that have excellent possibilities—especially at the present time—that these were engaging your attention more than the work of the laboratory. I remember that in my salad days I wrote an essay entitled the "Asylum superintendents and the Needs of the Insane." At that time I don't think I had ever seen an asylum superintendent nor any need of the insane; but my conclusions, as I remember them, were all the more emphatic that the superintendents and their administrative defects should be at once removed from civil life. Since those days a new spirit has developed in the field of psychiatry.

Once psychiatry was shut up in four walls and was looked at somewhat askance; but now the psychiatrist has come down into the market place and

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his service is demanded in the prisons, in the schools, by the employers of labor and by our government at the present time in organizing units fit and ready for war.

Probably all of you have heard of the figures, Dr. Bailey a short time ago stated that of the 300,000 troops sent from Canada there were 180,000 casualties and out of these casualties, as I recall, about 12 or 13 per cent were represented by nervous and mental diseases and that percentage was larger than all the casualties due to other disturbances befalling the medical men of all other specialties. You know also that whereas in ordinary times of peace the percentage of insanity is about 2 per thousand, this, in war times runs up to a ratio of 9 or 12 per thousand.

Now, in so far as the medical institutions of New York are of interest to you I don't know that I need say very much. You know what we have here; we have, as the Mayor has said, no great institutions in this city for mental diseases that are under municipal control. You know, however, that we have the largest state hospital in this country and perhaps in the world and I am sure its opportunities for studying this work will be offered to you. Psychiatry includes now the study of mental defects and abnormalities and I second the hope of the Mayor that you will take an opportunity to visit Randall's Island and see what work it is proposed to be instituted there. The Island houses and cares for 2000 children and young adults and they form an intensely interesting group of cases, illustrating modern methods of treatment and education. I think, too, that the activities which are going on in Bellevue Hospital will be of interest to you. There has been organized there, under Dr. Gregory, a system by which the alcoholics of the city, numbering nine or ten thousand a year, and the drug addicts are cared for; and there are some new methods of managing these groups of cases which are being carried out.

There is an institution on 67th Street, The Neurological Institute, where the connection between neurology and psychiatry is maintained and where we are trying to care for organic neurology and those borderland cases which are partly psychopathic and partly neuropathic. It is a modest institution but it is of a kind that ought to be developed in all large centers of the country and I believe that it is going to be the model for further work of this kind.

We ask your attention and criticism to the kind of work we are trying to develop here and I hope that you will find instruction and profit and will be free to give us suggestions and criticisms of the work we are doing.

I repeat, then, Mr. President, that in the name of the neurologists and psychiatrists, I welcome, most cordially, this Association to the city of New York.

THE PRESIDENT.—Permit me, Dr. Dana, to extend to you the thanks of our Association for your very kind address of welcome.

We have with us this morning a distinguished citizen of New York, whose presence here gives great pleasure, especially to all of the older members of the Association; a physician and surgeon of New York whose

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activities cover a long period, a period almost equal to the entire life of this Association, which is 73 years. A successful teacher of medicine, an able editor of medical journals, a writer of great ability, an author of text books on medicine and surgery, a contributor to our journals on many topics interesting to physicians; a physician, eminent alike in his hospital work and in his private practice; conspicuous in his life-long connections with public charities and with public health; a man whose lofty ideals have been an inspiration to all who have known him.

I now have the very great pleasure of introducing the nestor of the New York medical profession, Dr. Stephen Smith.

Dr. Smith, who was greeted with great applause, spoke as follows:

Mr. President, Members of the Association, Ladies and Gentlemen:

This Seventy-Third Annual Meeting of the American Medico-Psychological Association forcibly reminds me of a similar event which occurred in the year 1852. I refer to the Seventh Annual Meeting of the "Medical Superintendents of American Institutions for the Insane," which met on the 18th day of May of that year at the Irving House at the corner of Broadway and Chambers Street.

Being a graduate in medicine of but one year and an entire stranger in the city I naturally had much leisure for other entertainment than attending my patients. I was attracted to the sessions by the novelty of seeing the practisers in this branch of medicine and listening to their discussion of the weird subject "insanity."

As the Association of Medical Superintendents of American institutions for the Insane of 1852 was the American Medico-Psychological Association of to-day in its infancy, it may be pertinent to this occasion if, as a spectator of its Seventh Annual Meeting, I give my impressions of the personnel of its members and the subjects discussed. The number of registered members in attendance was 26 and among the names we recognize the pioneers of American psychiatry. The absence of two founders was noticeable, viz.: Dr. Samuel Bayard Woodward and Dr. Amariah Brigham, both of whom had recently died.

The President was Dr. Luther V. Bell, of the McLean Asylum, Somerville, Massachusetts, a tall, well-proportioned man, of courtly manners and adapted to the position of presiding officer of such a dignified body. He took a deep interest in the papers presented and skillfully brought before the members the various subjects for discussion.

Among the more notable members were Dr. Isaac Ray, Butler Hospital, R. I.; Dr. Edward Jarvis, Dorchester, Mass.; Dr. John S. Butler, of The Retreat for the Insane, Hartford, Conn.; Dr. C. H. Nichols, Bloomingdale Asylum, N. Y.; Dr. T. S. Kirkbride, Pennsylvania Hospital for the Insane, Philadelphia; Dr. H. A. Buttolph, State Lunatic Asylum, Trenton, N. J.; Dr. S. Hanbury Smith, Lunatic Asylum, Columbus, Ohio; Dr. Francis T. Stribling, Western Lunatic Asylum, Staunton, Va.; Dr. Thomas F. Green, State Lunatic Asylum, Ga.; Dr. C. Fremont, Canada.

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The members of the Association impressed me as educated gentlemen of a higher type of professional character than I had been accustomed to meet. The President, Dr. Bell, and several others answered well to the description of the founder, Dr. Woodward, of whom it is said, "His personal appearance was commanding, and his carriage majestic. . . . . He was erect, and, though full in figure, his motions were quick and graceful. Although very civil and acceptable to all he seemed born to command. Dignity and ever-enduring cheerfulness sat upon his countenance . . . ."

The session continued five days and the subjects discussed related chiefly to the construction, equipment and management of institutions for the insane. The proceedings were published in an eight-page pamphlet. Dr. Ray read a paper on the following subject assigned to him by the President:

"On the best methods of saving our hospitals for the insane from the odium and scandal to which such institutions are liable, and maintaining their place in the popular estimation; including the consideration of the question, how far is the community to be allowed access to such hospitals."

On motion of Dr. Kirkbride it was resolved:

"That the standing committee on construction of hospitals for the insane be requested previous to the next meeting of the Association to prepare a series of resolutions or propositions, affirming the well-ascertained opinions of this body in reference to the direction, organization and discipline of hospitals for the insane."

Dr. Stribling read a dissertation:

"On the employment of male attendants in the female wards of Lunatic Hospitals."

Dr. Kirkbride read a paper:

"On the comparative advantages of steam and hot water in heating hospitals for the insane, large and small, with an attempt to fix the ratio of radiating surface to the space to be warmed in the climate of the northern sections of the United States."

Dr. Jarvis made a partial report:

"On the connection between Insanity and crime."

The Association discussed:

"The proper disposition of insane criminals in state prisons."

Such were the subjects which engaged the thoughts and deliberations of the founders of your Association two generations past. It was the period of the custodial care of the insane and the location of asylums, the construction of buildings, their equipment, the methods of commitment, the mechanical restraint of the insane and similar subjects were living, vital questions. Insanity as a disease was based on the Pinel-Esquirol classification, viz.: its "symptomological expression." The brain as "the medium of sensation, will, and even thought, the highest of psychic functions," was a sealed book except to a few laboratory students. The somatic doctrine of the German schools, as the basis of interpretation of all psychic phenomena, had made a slight progress in this country. It is highly creditable to the genius of Dr. Luther V. Bell, President of the Seventh Annual

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Meeting of this Association, that he combated with great force the French theory of symptomatology and was sustained by van der Kolk, of Holland, Morel, of France, and other authorities. From these facts we infer that at the period referred to, 1852, neither insanity nor psychology had a scientific basis and that the superintendents of institutions for the insane were devoted to the care rather than to the cure of the inmates.

It is a far call from 1852 to 1917. The child of seven is now the sage of seventy-three. We scarcely trace in the latter a lineament of the former. The membership of 26 in 1852 was 827 in 1916; its constituency was formerly limited to a few states, but now it includes the United States and also Canada, Cuba and Porto Rico; its eight-page pamphlet of proceedings is now a volume of 400 to 600 pages, embracing every subject relating to insanity and the care of the insane. Even the name of the infant Association is but an item of record in history. The vast improvement in the care and treatment of the insane during the period 1852-1917 is a matter of common knowledge. That the initiative of these improvements and their practical application have been the fruitage of the intelligent and consecrated devotion of the members of this Association, impartial history will record in detail.

Members of the Association, I esteem it a great, indeed a remarkable privilege, that I am permitted to join in welcoming you to the hospitalities of New York City. It is a matter I think of record that the annual meetings of your Association in this city have given an impulse and an inspiration to its members, inciting to higher ideals and renewed consecration to the service of the insane. At no time in its history has New York furnished such facilities as now for education in the more abstruse medical sciences. Its 75 hospitals specialize every form of disease. Its medical colleges teach the principles and practice of the medical sciences and arts clinically, and its laboratories of research unfold the ultimate elements of health and sickness. These are all open to your visitation, inspection and inquiries. This is the sixth annual meeting of your Association in this city and I can assure you that the discussions in your meetings have a reciprocal effect in stimulating public inquiry and professional research in regard to the care and treatment of the insane in this city and state.

President Wagner, far back in the eighteen-eighties, I recall your cheerful manner and happy and helpful remarks to patients as we passed from bed to bed in the Utica Asylum. Your kind and sympathetic manners reminded me of Dr. Isaac Ray's description of the "Good Superintendent." "He never grudges the moments spent in quiet, familiar interview with them for thereby he gaineth many glimpses of their inner life that may help him in their treatment." I congratulate you on the occasion of your exaltation to the highest honors of your profession. Your success as superintendent and your elevation to the Presidency of this Association, has verified Dr. John P. Gray's remark, "Wagner will succeed in what he undertakes." I cannot resist the temptation of stating in this connection the pleasure it had given me to notice from time to time the progress in their profession of the young assistant physicians whose acquaintance

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I made in the hospitals for the insane in this state in the period 1882-1888. Macdonald, Blumer, Brush, Pilgrim, Wagner have attained to the Presidency of this Association, the highest honor in the gift of the profession.

Looking backwards through the long vista of 65 years, I realize that the workers in the field of American psychiatry, whom I knew in their active days, are now silent forever. In bringing to you, at this your Seventy-Third Annual Meeting, a greeting from one who attended the Seventh Annual Meeting of your Association, I may repeat the words of Job's messengers, "I only am escaped alone to tell thee."

THE PRESIDENT.—In expressing to Dr. Smith the thanks of the Association for his very interesting address, I cannot let the occasion pass without offering a personal expression of appreciation, for I have long felt that I too was one of Dr. Stephen Smith's pupils—one of his students. It is now more than 30 years since as an assistant physician I entered the Utica State Hospital, then known as the New York State Lunatic Asylum, but nothing stands out more clearly in my memory of that time than the visits of Dr. Smith as the State Commissioner in Lunacy. Dr. Smith made his visits at the institution, spending many days at a time, going through the wards and seeing the patients, personally talking with them and encouraging them. He was not only interested in the patients but he was very kind to the assistant physicians on the staff. He never tired of drawing upon his inexhaustible experience and fund of information for the benefit and education of those young men.

Dr. Smith was far in advance of his time in those days. He appreciated the wrong that was done the insane by detaining them in the county poorhouses and he not only made continuous effort to have them removed to state institutions for their better care but drafted a law for the purpose of securing that end. The bill failed of passage during his term as commissioner owing to political interference at Albany, but a few years later, with some amendments, it passed the legislature and became the State Care Act, under which all of our institutions for the care of the insane in the state of New York are operating to-day. (Applause.)

So, to Dr. Smith we owe the great impetus which resulted in the emancipation of the insane of the state of New York from the poorhouse care that existed throughout the state prior to the last decade of the nineteenth century.

Dr. Smith has always been deeply interested in the upbuilding of the state hospitals. He was one of the pioneers in organizing their training schools for nurses. He did more to establish these schools in our state hospitals than any one else; and at the first graduation exercises, which were held in the early eighties in the Buffalo State Hospital, if I remember correctly, Dr. Smith made the graduation address to the nurses. On behalf of the Association, Dr. Smith, I thank you for coming here this morning and giving us such a splendid address and I hope you will enjoy many years of good health in the future. (Great applause.)

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The reports of the committees are now in order. The first report is that of the Committee of Arrangements, Dr. Carlos F. MacDonald has been indefatigable in his efforts to provide for the entertainment of the Association at this meeting and will now address you in making his report.

DR CARLOS MACDONALD.—*Mr. President, and Fellow Members of the Association:* Your Committee of Arrangements feels that it has been singularly fortunate in securing such a galaxy of distinguished speakers to attend here this morning for the purpose of welcoming the Association to the city of New York.

As the work of securing these speakers was delegated to me, as Chairman of the committee, I may be pardoned for expressing a sense of personal gratification which I feel respecting the success attending my efforts. I must confess that, knowing what a busy man he is, and how excessive are the demands upon him, both official and social, I approached His Honor, Mayor Mitchel—who, by the way, is one of the best mayors New York has ever had—with not a little misgiving as to obtaining a favorable response to my invitation on behalf of the committee to come here and deliver an address of welcome to the Association. In fact, I was quite prepared to meet with a courteous refusal, and was agreeably disappointed when His Honor most graciously and willingly consented to come.

The other speakers, Doctors Stephen Smith, Walter B. James and Charles L. Dana, all eminent men of our own profession, are too well known to the most of the members of this Association to require any special comment from me beyond saying that I am sure I voice the sentiments of the Association when I say that we all feel highly honored and greatly indebted to these gentlemen for their gracious attendance here to-day, and I may be pardoned for making special mention of Dr. Stephen Smith—who was my honored preceptor when a medical student—whose eminent attainments in surgery, sanitary science, public charities, a successful teacher of medicine, and as State Commissioner in Lunacy in the state of New York, place him at once among the nestors of our profession, which he has conspicuously adorned for nearly three-quarters of a century.

The Committee on Arrangements has also been fortunate in securing contributions to the amount of $975.00, which we hope will be ample to meet the necessary expenditures of our program of entertainment for the Association. It would seem proper in this connection to mention the name of a gentleman who, although not a member, is well known to nearly every member of this Association—I refer to Mr. C. W. McCarty, of the American Laundry Machinery Company. Mr. McCarty volunteered to undertake the onerous work of soliciting contributions—in other words, of doing the begging, a work in which I think no member of the Committee of Arrangements could possibly have been successful without his assistance.

The program for the social entertainment of the members of the Association and their families and guests is as follows:

On Wednesday, there will be an excursion on the steamer *Wanderer* around New York Harbor and up the Hudson River. The boat will leave

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the pier, East 34th Street, at 1.30 p. m., returning about 5 p. m. A buffet lunch will be served on the boat. The committee requests that members who intend to take this trip, including their families, will please register early in order that ample accommodations may be provided; and, also for the reason that the banquet department of this hotel desires to know how many will probably have to be served with refreshments on the evening of the President's reception. On Wednesday evening, after the annual address by Edwin G. Conklin, Professor of Biology, Princeton University, the President's reception will be held in the ball room of the Hotel Astor at which refreshments will be served and dancing will follow. On Thursday afternoon the ladies in attendance are invited to take a sight-seeing tour by motor busses, leaving the Hotel Astor at 2.30 p. m. The trip will include Riverside Drive, with a stop of 15 minutes at Grant's Tomb, returning through Central Park and Fifth Avenue. This covers substantially all that has been arranged for in the way of social entertainment.

In this connection the committee would suggest the following places of psychiatric interest in and near New York—that is, in Greater New York and vicinity: Manhattan State Hospital and Psychiatric Institute, Ward's Island, reached by steamer from the foot of East 116th Street, boats run every half hour; Brooklyn State Hospital, Clarkson Street and Albany Avenue, subway to Atlantic Avenue, Flatbush Avenue car; Kings County Hospital, Psychopathic Pavilion, near the Brooklyn State Hospital; Manhattan State Hospital for Criminal Insane, Beacon, N. Y., reached via New York Central Railroad; Kings Park State Hospital, Kings Park, L. I., about 45 miles from New York City, reached from Pennsylvania Station via Long Island Railroad; Central Islip State Hospital, Central Islip, L. I., about 40 miles from New York, reached from Pennsylvania Station via Long Island Railroad; Bloomingdale Hospital, White Plains, about 22 miles from Grand Central Terminal; New York City Children's Hospital and School, Randall's Island, boat from E. 120th St., every half hour; Bellevue Hospital, Psychopathic Department, East 28th Street and First Avenue, reached by 23d Street car to First Avenue; Police Laboratory, Police Headquarters, 240 Centre Street; Psychiatric Clinic, Department of Correction, Blackwell's Island, ferry from foot of East 53d Street; Children's Court, Psychiatric Clinic, East 22d Street, between Lexington and Third Avenues; Sing Sing Prison, Psychiatric Clinic, Ossining, 30 miles from New York, via New York Central; National Committee for Mental Hygiene, 50 Union Square.

The work of the Committee on Arrangements has been a labor of love on the part of its members, particularly Doctors Pilgrim, Russell and Kirby, who have attended the meetings and have taken an active part in the work.

I can assure the members of the Association that we are pleased and gratified at having this meeting in New York, and we hope that under President Wagner's able administration it will be one of the most successful meetings the Association has ever had.

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THE PRESIDENT.—While the iron is hot, let us strike; I will ask if some one will offer a motion tendering a vote of thanks to Mr. McCarty for his able assistance in providing such an acceptable series of entertainments for this meeting.

DR. BRUSH.—Mr. President, in rising to make that motion, I want to preface it with a motion of thanks to the Committee of Arrangements for the efforts they have put forth to make this a specially interesting meeting. I think all of us have carried away on previous occasions pocket knives, bedside lamps and other souvenirs given us by Mr. McCarty and we have always enjoyed his genial presence at these meetings. He has always seemed to take as much interest in the meetings as if he were a member himself, and I think we can do no less than to acknowledge our high appreciation of the work of Mr. McCarty in the aid given by him to the Committee of Arrangements in collecting funds for the entertainment of the Association.

I move that the thanks of the Association be tendered the Committee of Arrangements coupling therewith the name of Mr. Chas. W. McCarty for the excellent work done on this occasion.

The motion was seconded by Dr. Pilgrim and adopted unanimously.

THE PRESIDENT.—I would like to add one or two announcements to those read by Dr. MacDonald. One is in the nature of a communication from the National Committee for Mental Hygiene, 50 Union Square. The Committee extends a cordial invitation to all members of the Association to visit the office of the Committee and gain information there as to the scope and activity of its work. The other is from Dr. B. D. Evans, Superintendent of the New Jersey State Hospital at Morris Plains, who has requested me to announce that he would be glad to see the Association collectively or individually at the Morris Plains State Hospital and assures everyone a cordial welcome.

I wish to remind you to register; not only the members of the Association, but our guests as well. We desire a complete record of all who have attended this meeting.

Last evening, in conformity with our custom and the requirements of the constitution, the Council held its meeting and transacted considerable business. I will call upon the Secretary for the Council's report.

THE SECRETARY.—*Mr. Chairman and Members of the Association:* The following is the report of the Council to the American Medico-Psychological Association:

NEW YORK, May 29, 1917.

The Council met on the evening of May 28, at the Hotel Astor, New York City.

The Council recommends for election to active membership the following named physicians: This list was presented to the Association a year ago and these names are now submitted for final consideration.

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Felix M. Adams, M. D., Vinita, Okla.; Charles R. Ball, M. D., St. Paul, Minn.; Edwin P. Bledsoe, M. D., Little Rock, Ark.; Robert Morris Butler, M. D., Jackson, Miss.; Charles Macfie Campbell, M. D., Baltimore, Md.; Lionel L. Cazenavette, M. D., New Orleans, La.; Marcel J. De Mahy, M. D., New Orleans, La.; John W. Duke, M. D., Guthrie, Okla.; Edward J. Engberg, M. D., St. Paul, Minn.; Charlotte S. Farrington, M. D., Philadelphia, Pa.; Henry G. Gahagan, M. D., Elgin, Ill.; James Greenwood, M. D., Houston, Tex.; Ernest M. Hammes, M. D., St. Paul, Minn.; Charles B. Hill, M. D., Supply, Okla.; Andrew W. Hoisholt, M. D., Napa, Cal.; Arthur G. Hyde, M. D., Cleveland, Ohio; H. C. Kehoe, M. D., Frankfort, Ky.; Cheston King, M. D., Atlanta, Ga.; William S. Lindsay, M. D.; Topeka, Kans.; S. Metz Miller, M. D., Norristown, Pa.; Angus W. Morrison, M. D.; Mimeapolis, Minn.; Joseph A. O'Hara, M. D., New Orleans, La.; F. L. Peddicord, M. D., Lakeland, Ky.; Harriet E. Reeves, M. D., Melrose, Mass.; G. E. Scrutchfield, M. D., Farmington, Mo.; Charles V. Unsworth, M. D., New Orleans, La.; A. F. Young, M. D., Milwaukee, Wis.; Beverly Young, M. D., San Antonio, Texas.

The Council recommends that the following named physicians be named for associate membership:

J. F. Leigh Brown, M. D., Southampton, N. B.; Walter Burrier, M. D., Medfield, Mass.; Carolyn Clark, M. D., Marion, Va.; Helen Taft Cleaves, M. D., Monson, Mass.; Fred Conzelman, M. D., Stockton, Cal.; Thomas Cuddy, M. D., Wellesley, Mass.; Augustus B. Dykman, M. D., Poughkeepsie, N. Y.; B. F. Frazer, M. D., Osawatomie, Kans.; Edward Thomas Gibson, M. D., Middletown, Conn.; Hugh S. Gregory, M. D., Ogdensburg, N. Y.; John F. Hackett, M. D., Mansfield Depot, Conn.; John J. Harrington, M. D., Osawatomie, Kans.; Stephen P. Jewett, M. D., New York, N. Y.; Wm. A. MacIntyre, M. D., North Grafton, Mass.; Fred L. McDaniel, M. D., Osawatomie, Kans.; George E. McPherson, M. D., Medfield, Mass.; P. B. Means, M. D., Trenton, N. J.; Lester F. Norris, M. D., Bangor, Me.; Walter Joseph Otis, M. D., Waverley, Mass.; Arthur E. Pattrell, M. D., North Grafton, Mass.; Cyrus E. Pringle, M. D., Buffalo, N. Y.; Hamilton Rinde, M. D., Middletown, Conn.; Leigh F. Robinson, M. D., Raleigh, N. C.; Margaret Smythe, M. D., Stockton, Cal.; Wm. S. Walsh, M. D., West Pownal, Me.

The Council has received the following applications for active membership:

G. E. Charlton, M. D., Norfolk, Neb.; Harvey Clare, M. D., Toronto, Ont.; Albert H. Dollear, M. D., Jacksonville, Ill.; Winfield S. Farmer, M. D., Nashville, Tenn.; Wm. S. Fast, M. D., Ingleside, Neb.; C. C. Kirk, M. D., Little Rock, Ark.; Wm. T. Kradwell, M. D., Wauwatosa, Wis.; F. G. La Rue, M. D., Hopkinsville, Ky.; Ralph Reed, M. D., Cincinnati, Ohio; Arthur H. Ring, M. D., Arlington Heights, Mass.; Del Parde W. Roberts, M. D., Milwaukee, Wis.; Rock Sleyster, M. D., Waupun, Wis.; Wm. J. Steward, M. D., Pennhurst, Pa.; Fulton S. Vrooman, M. D., Coburg, Ont.; Samuel B. Woodward, M. D., Worcester, Mass.; Lesser Kauffman, M. D., Buffalo, N. Y.; Beverley R. Tucker, M. D., Richmond, Va.; W. Reid Putney, M. D., Amelia, Va.; A. R. T. Wylie, M. D., Grafton, N. Dak.; Arthur P. Noyes, M. D.,

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Boston, Mass.; Wm. Healy, M. D., Boston, Mass.; J. Allison Hodges, M. D., Richmond, Va.

In accordance with the constitution final consideration of these will be deferred until next year.

The Council recommends the transfer of the following named associate members to the active class:

Paul J. Alspaugh, M. D., Massillon, Ohio; Earl D. Bond. M. D., Philadelphia, Pa.; Edgar L. Braunlin, M. D., Dayton, Ohio; George F. Brewster, M. D., New York, N. Y.; H. M. Brundage, M. D., Columbus, Ohio; Ross McC. Chapman, M. D., Washington, D. C.; E. H. Cohoon, M. D., Boston, Mass.; Arrah B. Evarts, M. D., Washington, D. C.; John B. McDonald, M. D., Hathorne, Mass.; A. C. Matthews, M. D., Napa, Cal., H. C. Podall, M. D., Norristown, Pa.; Charles F. Read, M. D., Watertown, Ill.; Ralph S. Reed, M. D., Central Islip, N Y.; Arthur H. Ruggles, M. D., Providence, R. I.; Wm. B. Terhune, M. D., Jackson, La.; Tom B. Throckmorton, M. D., Des Moines, Ia.; Adaline Westcott, M. D., Newburgh, N. Y.; Esther S. B. Woodward, M. D., White Plains, N. Y.

The Council reports the following deaths during the year:

Dr. R. W. Bruce Smith, Dr. Charles F. Gilliam, Dr. R. H. Parsons, Dr. Victor A. Bles, Dr. Charles H. Hughes, Dr. C. Von A. Schneider, Dr. Wm. Mabon, Dr. Elliot Gorton, Dr. M. J. White, Dr. G. H. Moody.

The Council recommends to the Association that the sum of $2500 be set aside from the surplus funds in the hands of the Treasurer of the Association to be applied upon the deficit in the publication of the Institutional Care of the Insane. The Council also recommends that the managing editor of the AMERICAN JOURNAL OF INSANITY, after conference with the Secretary of the Johns Hopkins Press, transfer the sum of $500, more or less, to be applied to meeting the deficit incurred in the printing of the Institutional Care of the Insane in the United States and Canada.

The Council reports that it has appointed a committee to dispose of the remaining volumes of the above work with power to fix the price to be charged therefor; the proceeds of the sale of such volumes to be applied upon the cancellation of the above two advances.

THE PRESIDENT,—I might add a word in reference to the work The Institutional Care of the Insane in the United States and Canada and that is as matters now stand there is a shortage in the expense account of approximately $3000 for which Dr. Henry M. Hurd is assuming responsibility, and the Council believes that as the Association directed this work and assumed sponsorship for it the Association should now, at once, relieve Dr. Hurd from all embarrassment and to do that we have funds amounting to about $2500 in the hands of the Treasurer which we can devote to that purpose. Furthermore, Dr. Brush states that he can contribute from the AMERICAN JOURNAL OF INSANITY about $500 additional, which might be sufficient to wipe out the debt. Then we shall have 600 sets of the history that will belong to the Association, and a committee has been appointed to undertake the disposition of as many of these sets as possible. The Association will be asked, in place of an assessment, to voluntarily increase subscriptions at the institutions where the members are located or to buy

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them personally or in any way they like to secure the sale of a considerable part of the volumes we still have on hand. It is an exceedingly valuable history and every institution and every library should have it; an active campaign will undoubtedly result in the sale of the volumes now on hand.

DR. BRUSH.—*Mr. President:* I would like to make a suggestion as to the deficiency resulting from the publication of the work of which Dr. Hurd is the editor. I know about the shortage only by rumor. Just before I left Baltimore I received a letter from Dr. Hurd in which he said he had sent his report as editor of the volumes to some member of the Editorial Committee, perhaps to Dr. Burgess; and it seemed to me that perhaps it would be wise to defer any positive action on this matter until we learn whether Dr. Hurd's letter is here, what the status is and also as to any advice he has included in his report.

THE PRESIDENT.—Then that part of the report referring to the transfer of the funds will be withdrawn by the Secretary for the present until we ascertain what Dr. Hurd's report contains and this will be submitted at a later session. The other matters are before the Association for such disposal as it desires to make. A motion to approve the action of the Council will be in order.

DR. ASHLEY.—Mr. President, I move that the action of the Council taken last night be approved by the Association.

The motion was seconded and adopted unanimously.

DR. MACDONALD.—Mr. President, may I urge on behalf of the Committee on Arrangements that all members present with their guests will register as soon as possible concerning the boat trip; and the banquet department of this hotel would be very glad to know the number who will probably have to be served with light refreshments on the evening of the President's reception.

THE PRESIDENT.—The Treasurer will now make his report.

The following is a statement of membership of the American Medico-Psychological Association to date:

HONORARY MEMBERS.

Present number		18

LIFE MEMBERS.

Present number		27

ACTIVE MEMBERS.

Former number	465	
Associate to Active	8	
Admitted	19	
Active to life	9	
Resigned	2	
Dropped	11	
Died	8	
Present number		462

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ASSOCIATE MEMBERS.

Former number	323	
Admitted	40	
Associate to Active	8	
Resigned	6	
Dropped	8	
Died	3	
Present number		338
Total membership May 29, 1917		845

REPORT OF TREASURER, 1916-1917.

DEBITS.

Balance brought forward	$3,561.07
Received for dues:	
Active members	2,300.00
Associate members	643.00
Advance dues	22.00
Interest on deposits:	
First National Bank, Massillon	44.38
Mutual Building & Investment Co., Cleveland, Ohio	152.80
Miscellaneous:	
Sale of gummed lists	10.50
Sale of copies of Transactions	2.00
Sale of old paper	1.00
Total	$6,736.75

CREDITS

1916			
April	10	Perry & Buckley Co., printing ballots	$17.25
	10	T. E. McGarr, stenographic services	50.00
	10	H. C. Eyman, expense at New Orleans meeting	13.41
	10	Arthur J. Herring, expense for exhibit	87.40
	13	E. A. Rigdon, stamps	.50
	13	Wm. A. White, postage	4.48
	17	W. L. Russell, envelopes	1.82
	20	E. A. Rigdon, stamps	.50
	20	The School & Office Supply Co., copying letters	1.35
May	12	Protested check, F. J. Hammond	2.00
	15	E. A. Rigdon, stamps	1.50
	29	Lord Baltimore Press	1,137.93
June	1	Ohio Printing & Publishing Co., letter heads	4.80
	1	T. E. McGarr, stenographic services	125.00
	2	E. A. Rigdon, express charges	.34
	27	E. A. Rigdon, stamps	.50

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Sept.	5	Ohio Printing & Publishing Co., printing	$10.00
	5	H. C. Eyman, expenses to New York	25.00
	16	Chas. Ream, express charges	1.60
	16	Johns Hopkins Press, reprints and transactions	21.50
	16	E. A. Rigdon, stamps	.50
Oct.	13	E. A. Rigdon, stamps	10.00
	17	Ohio Printing & Publishing Co., circular letters	3.75
	23	Ohio Printing & Publishing Co., envelopes	22.85
	23	E. A. Rigdon, stamps	.50
Nov.	14	E. A. Rigdon, stamps	.50
	24	H. B. Sibila, p. m. stamps	4.35
	27	E. A. Rigdon, stamps	.50
Dec.	15	E. A. Rigdon, stamps	1.00
	21	Ohio Printing & Publishing Co., letters heads and printing	33.15

CREDITS.

1917			
Jan.	16	E. A. Rigdon, stamps	.50
	18	Beulah Harpold, stenographic services	100.00
Feb.	19	E. A. Rigdon, stamps	1.00
Mar.	28	Ohio Printing & Publishing Co., printing	38.60
April	2	H. B. Sibila, stamps	20.40
	16	Dr. R. H. Hutchings, expense	58.45
	23	H. C. Eyman, expenses to Buffalo	21.00
May	5	E. A. Rigdon, stamps	.50
	8	H. B. Sibila, p. m. stamps	10.00
	11	H. B. Sibila, p. m. stamps	7.00
	17	Henry M. Hurd, history account	93.50
	17	E. A. Rigdon, clerical services	35.00
	18	Ohio Printing & Publishing Co., programs, envelopes and inserts	105.75
	19	The Park Press, printing ballots	3.00
	21	A. P. Herring, expense attending meeting of Committee on Diversional Occupation	17.94
	21	Wm. Rush Dunton, expense attending meeting of Committee on Diversional Occupation	23.88
	21	Ohio Printing & Publishing Co., envelopes	23.35
		Total expenditures	$2,143.65
		Balance on hand as follows:	
		First National Bank, Massillon, Ohio	2,440.10
		Mutual Bldg. & Investment Co., Cleveland, Ohio	2,152.80
		Total	$6,736.75

Respectfully submitted,

HENRY C. EYMAN, *Treasurer.*

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THE PRESIDENT.—The report of the Treasurer will be referred to the auditors and by them will be submitted to the Association. We will now call for a report of the editors of the JOURNAL OF INSANITY.

DR. BRUSH.—Mr. President, the editors of the JOURNAL OF INSANITY have nothing remarkably new to present. Those of you who subscribe to the JOURNAL have the pleasure of reading it and those who do not subscribe don't know what they are losing; they have missed something out of their lives and if they want to live long and happily they must send on their subscriptions. The JOURNAL has been met with the increased cost of living—with the higher prices for paper, ink and composition, so that payments for the JOURNAL have during the past year been larger than the previous years.

We feel, at least I feel, I have not had an opportunity of conferring with my associates on the board, that quite possibly if the necessity arises we can contribute from the funds of the JOURNAL a sum approximating $500 to help wipe out the indebtedness on the Institutional Care of the Insane in the United States and Canada, three volumes of which have been published and the fourth volume of which is now in press.

I would like to say a word or two to the contributors of the JOURNAL, and particularly to you gentlemen who are down for papers on the program: Please send your manuscript to the JOURNAL in the form in which you want it printed. I do not know that you all realize that when a manuscript is put in type and sent to the author for proof corrections and he re-writes several paragraphs and strikes out others and puts in new sentences and clauses that he is causing the JOURNAL an expenditure amounting some times to more than the original cost of setting up his article. We furnish the JOURNAL to members of the Association at a minimum price and reasonable illustrations are supplied and we are always glad to make such corrections in the proof as are due to printers' errors, but we do believe that when a gentleman sends his manuscript to us he ought to send it in the shape in which he wishes it printed. After he has received his proof we feel that if he wants to rewrite his article he should stand the cost incurred in resetting the type. By observing these suggestions contributors can help us in meeting the high cost of paper and other supplies. I would ask that these vouchers be referred to the auditing committee.

THE PRESIDENT.—The financial report of the JOURNAL will be referred to the auditing committee for examination.

At this time it is the duty of the President to appoint the nominating committee. I shall name as the committee charged with the important duty of nominating officers for the ensuing year, Dr. Carlos F. MacDonald, of New York; Dr. H. W. Mitchell, of Pennsylvania and Dr. Edward N. Brush, of Maryland.

At the meeting in New Orleans last year, some matters appeared in daily newspapers erroneously and a resolution was adopted that a committee on publicity should be appointed to look after the publication of such news concerning the Association's activities as might be thought

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interesting and desirable. I will, therefore, appoint as such committee, Drs. Chas. W. Pilgrim, William L. Russell and Isham G. Harris. Another committee that I will name at this time is the committee on awards for excellence of the exhibits in the adjoining room and we shall go outside of the Association for some of its members. I will name as the members of this committee Mr. George A. Hastings, Executive Secretary of the State Charities Aid Association; Dr. Frankwood Williams; Dr. Jesse Coggin; Dr. W. W. Richardson and Miss Susan C. Johnson.

Our program calls for a recess at this time for registration of members and visitors. I think, however, it would be well on account of the length of the program to omit the recess. You have all been requested to register, both our members and our guests, and I hope you will improve the opportunity very soon by seeing that your names are duly recorded. We desire a full list of all who attend, not only our members but our visitors as well. Another very important matter is to inform the registration committee whether you expect to attend the function on Wednesday evening or not, This is an important thing for the hotel to know and we hope that every one who can do so will attend. Also, we would be glad to have every one who intends to take the boat trip Wednesday afternoon indicate his desire so that arrangements to accommodate everybody may be made.

We now have a duty to perform in memory of our deceased members. During the year a number of our associates have gone to that "bourne whence no traveler returns," and friends have kindly drafted tributes to their memory.

I will ask Dr. Eyman, the Secretary, to read the names of those who have departed this life during the year and the names of those who have prepared memorial notices and ask the members and friends present to stand while these are being read.

The Secretary, Dr. Eyman, then read the following list of memorial notices:

Richard H. Parsons, M. D., by Dr. B. D. Evans; Carl von Arx Schneider, M. D., by Dr. C. A. Potter; Charles Frederick Gilliam, by Dr. Guy H. Williams; R. W. Bruce Smith, M. D., by Dr. C. K. Clarke; William Mabon, M. D., by Dr. Charles W. Pilgrim; Eliot Gorton, M. D., by Dr. Thomas P. Prout; Charles Hamilton Hughes, M. D., by Dr. C. R. Woodson; Henry P. Frost, M. D., by Dr. ———; George H. Schwinn, M. D., by Dr. William A. White; Victor A. Bles, M. D., by Dr. Ralph H. Hinton.

THE PRESIDENT.—The time has arrived for the President to inflict upon the Association the presidential address.

The President then read the address which was received with continuous applause.

DR. BRUSH.—Mr. Secretary, as the vice-president is not in the chair, I must ask you to put a motion which I am sure everyone in the room will rise to support; that is, that the thanks of the Association be extended to

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Dr. Wagner on the occasion of the inspiring address that we have heard him deliver to-day.

Secretary Eyman put the motion which, after being seconded, was adopted unanimously by a rising vote.

The President thanked the Association for its kind action and a recess was taken until 2.30 p. m.

The following members registered and were in attendance during the whole or a part of the meeting:

Abbot, E. Stanley, M. D., Assistant Physician McLean Hospital, Waverley, Mass.

Allen, H. D., M. D., Superintendent Allen's Invalid Home, Milledgeville, Georgia.

Allen, J. Berton, M. D., Assistant Physician Central Islip State Hospital, Central Islip, N. Y.

Amsden, George S., M. D., Assistant Physician Bloomingdale Hospital, White Plains, N. Y.

Anderson, Albert, M. D., Superintendent State Hospital, Raleigh, N. C.

Anderson, Paul V., M. D., Resident Physician, Westbrook Sanatorium, Richmond, Va.

Anglin, James V., M. D., Medical Superintendent The Provincial Hospital, St. John, N. B.

Ashley, M. C., M. D., Superintendent Middletown State Hospital, Middletown, N. Y.

Baker, Amos T., M. D., Examiner Police Department, New York City, Elmhurst, N. Y.

Ball, Jau Don, M. D., Alameda County Hospital, Oakland, Cal.

Bancroft, Chas. P., M. D., Superintendent New Hampshire State Hospital, Concord, N. H.

Barlow, Chas. A., M. D., Superintendent Spencer State Hospital, Spencer, W. Va.

Barnhardt, W. N., M. D., Assistant Physician Central Islip State Hospital, Central Islip, N. Y.

Barrett, Albert M., M. D., Medical Director State Psychopathic Hospital, University of Michigan, Ann Arbor, Mich.

Barry, R. Grant, M. D., Assistant Physician, New Jersey State Hospital, Trenton, N. J.

Beling, Christopher C., M. D., Visiting Alienist Psychopathic Department, Newark City Hospital, Newark, N. J.

Bentley, Inez A., M. D., Woman Physician Kings Park State Hospital, Kings Park, N. Y.

Beutler, W. F., M. D., Superintendent Milwaukee Asylum for the Chronic Insane, Wauwatosa, Wis.

Blaisdell, R. E., M. D., Senior Assistant Physician Kings Park State Hospital, Kings Park, N. Y.

Blumer, G. Alder, M. D., Medical Superintendent Butler Hospital, Providence, R. I.

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Bond, Earl D., M. D., Senior Assistant Physician, Pennsylvania Hospital, Philadelphia, Pa.

Bond, George F. M., M. D., Physician in Charge Dr. Bond's House, Yonkers, N. Y.

Bradley, Isabel A., M. D., Assistant Physician, Columbus State Hospital, Columbus, Ohio.

Brewster, Geo. F., M. D., Alienist Children's Court, New York City.

Briggs, Lloyd Vernon, M. D., Secretary Massachusetts Committee for the Treatment and Care of Soldiers Suffering from Mental and Nervous Diseases, Boston, Mass.

Brodsky, Emanuel S., M. D., Assistant Medical Superintendent, Westport Sanatarium, Westport, Conn.

Brown, G. W., M. D., Superintendent Eastern State Hospital, Williams burg, Pa.

Brush, Edw. N., M. D., Physician-in-Chief and Superintendent, Sheppard and Enoch Pratt Hospital, Towson, Baltimore Co., Md.

Brown, Louis R., M. D., Assistant Physician Connecticut Hospital for the Insane, Middletown, Conn.

Buchanan, J. M., M. D., Superintendent East Mississippi Insane Hospital, Meridian, Miss.

Buckley, Albert C., M. D., Clinical Director Friends' Hospital, Frankford, Philadelphia, Pa.

Buckley, Jas. M., D. D., LL. D. (Honorary Member), Morristown, N. J.

Burdick, Chas. M., M. D., Senior Assistant Physician, Central Islip State Hospital, Central Islip, N. Y.

Burgess, T. J. W., M. D., Medical Superintendent, Protestant Hospital for Insane, Montreal, Que.

Burnett, S. Grover, M. D., Superintendent Burnett Sanitarium, Kansas City, Mo.

Burr, C. B., M. D., Medical Director "Oak Grove," Flint, Mich.

Burr, Chas. W., M. D., University of Pennsylvania, Philadelphia, Pa.

Capron, Arthur J., M. D., President and Physician in Charge, Glenmary Sanitarium, Owego, N. Y.

Carlisle, Chester Lee, M. D., Senior Assistant Physician, Kings Park State Hospital, Kings Park, N. Y.

Carmichael, F. A., M. D., Superintendent Osawatomie State Hospital, Osawatomie, Kans.

Chapman, Ross McC., M. D., First Assistant Physician, St Elizabeth's Hospital, Washington, D. C.

Cheney, Clarence O., M. D., Assistant Physician Manhattan State Hospital, Ward's Island, N. Y.

Clark, Chas. H., M. D., Superintendent, Lima State Hospital, Lima, Ohio.

Clark, J. Clement, M. D., Superintendent Springfield State Hospital, Sykesville, Md.

Coffin, Harriet F., M. D., Assistant Physician Kings Park State Hospital, Kings Park, N. Y.

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Coggins, Jesse C., M. D., Medical Director, The Laurel Sanatorium, Laurel, Md.

Cohoon, E. H., M. D., Superintendent Medfield State Hospital, Harding, Mass.

Colburn, Arthur B., M. D., Assistant Physician Connecticut Hospital for the Insane, Middletown, Conn.

Cook, Robert G., M. D., Resident Physician Brigham Hall, Canandaigua, N. Y.

Copp, Owen, M. D., Physician and Superintendent, Pennsylvania Hospital for the Insane, Philadelphia, Pa.

Cornell, William Burgess, M. D., Medical Director New York City Children's Hospital and School, Randall's Island, New York City.

Cotton, Henry A., M. D., Medical Director New Jersey State Hospital, Trenton, N. J.

Craig, Anna, M. D., Woman Physician Kings Park State Hospital, Kings Park, N. Y.

Curry, Marcus A., M. D., Assistant Physician New Jersey State Hospital, Greystone Park, N. J.

Davies, Geo. W., M. D., Assistant Physician Essex County Hospital, Cedar Grove, N. J.

Devlin, F. E., M. D., Assistant Medical Superintendent, Hospital St. Jean de Dieu, Gamelin, Que.

Dewey, Richard, M. D., Physician-in-Charge, Milwaukee Sanitarium, Wauwatosa, Wis.

Dold, Wm. Elliott, M. D., Medical Superintendent, River Crest Sanitarium, Astoria, L. I.

Donohue, Geo., M. D., Superintendent Cherokee State Hospital, Cherokee, Iowa.

Drewry, Wm. F., M. D., Central State Hospital, Petersburg, Va.

Durgin, Delmer D., M. D., Assistant Physician Central Islip State Hospital, Central Islip, N. Y.

Eastman, Frederick C., M. D., Brooklyn, N. Y.

Elliott, Robert M., M. D., Superintendent Willard State Hospital, Willard, N. Y.

Emerick, E. J., M. D., Superintendent Institution for Feeble-Minded, Columbus, Ohio.

English, W. M., M. D., Medical Superintendent, Hospital for Insane, Hamilton, Ont.

Evans, Britton D., M. D., Medical Director, New Jersey State Hospital, Morris Plains, Greystone Park, N. J.

Eyman, Henry C., M. D., Superintendent Massillon State Hospital, Massillon, Ohio.

Faison, W. W., M. D., Superintendent State Hospital, Goldsboro, N. C.

Finlayson, Alan D., M. D., Senior Assistant Physician, Warren State Hospital, Warren, Pa.

Fisher, E. Moore, M. D., Senior Assistant Physician, New Jersey State Hospital, Morris Plains, Greystone Park, N. J.

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Flood, Everett, M. D., Superintendent Monson State Hospital, Palmer, Mass.

Folsom, Ralph P., M. D., Senior Physician Manhattan State Hospital, Ward's Island, New York City.

Forster, J. M., M. D., Medical Superintendent, Hospital for Insane, Toronto, Ont.

Fuller, Daniel H., M. D., Senior Assistant Physician, Pennsylvania Hospital for the Insane, Philadelphia, Pa.

Fuller, Solomon Carter, Md., Pathologist Westborough State Hospital, Westborough, Mass.

Garvin, Wm. C., M. D., First Assistant Physician, Kings Park State Hospital, Kings Park, N. Y.

Givens, Amos J., M. D., Proprietor Dr. Givens' Sanitarium, Stamford, Conn.

Glascock, Alfred, M. D., Senior Assistant Physician St. Elizabeth's Hospital, Washington, D. C.

Gosline, Harold I., M. D., Pathologist New Jersey State Hospital, Trenton, N. J.

Granger, William D., M. D., Superintendent Vernon House, Bronxville, N. Y.

Green, Edw. M., M. D., Clinical Director Georgia State Sanitarium, Milledgeville, Ga.

Green, Edw. C., M. D., First Assistant Physician Northampton State Hospital, Northampton, Mass.

Griffin, David W., M. D., Superintendent Central State Hospital, Norman, Okla.

Grover, Milton W., M. D., Assistant Physician Kings Park State Hospital, Kings Park, N. Y.

Hall, G. Stanley, Ph. D., LL. D., President Clark University, Worcester, Mass. (Honorary.)

Hamilton, S. W., M. D., Director Psychopathic Laboratory, Police Department, New York City.

Hancker, William H., M. D., Medical Superintendent, Delaware State Hospital, Farnhurst, Del.

Harrington, Arthur H., M. D., Superintendent State Hospital for Mental Diseases, Howard, R. I.

Harris, Isham G., M. D., Superintendent Brooklyn State Hospital, Brooklyn, N. Y.

Haskell, Robert H., M. D., Medical Superintendent, Ionia State Hospital, Ionia, Mich.

Hasking, Arthur P., M. D., Examiner of Indigent Insane, Hudson County, N. J., Jersey City, N. J.

Hassall, Jas. C., Clinical Director, St. Elizabeth's Hospital, Washington, D. C.

Haviland, C. Floyd, M. D., Superintendent Connecticut Hospital for the Insane, Middletown, Conn.

Hawke, W. W., M. D., Eurie Sanitarium, Clifton Heights, Pa.

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Hedin, Carl J., M. D., Superintendent Maine School for Feeble-Minded, West Pownal, Me.

Henderson, Estelle H., M. D., Superintendent Southwestern State Hospital, Marion, Va.

Henschel, Louis K., M. D., Senior Assistant Physician, New Jersey State Hospital, Morris Plains, N. J.

Herring, Arthur P., M. D., Secretary Maryland Lunacy Commission, Baltimore, Md.

Heyman, Marcus B., M. D., Medical Inspector New York State Hospital Commission, Ward's Island, New York City.

Hill, Chas. G., M. D., Physician-in-Chief, Mt. Hope Retreat, Baltimore, Md.

Hill, Gershom H., M. D., Superintendent "The Retreat," Des Moines, Iowa.

Hill, Samuel S., M. D., Superintendent and Chief Physician State Asylum, Wernersville, Pa.

Hinckley, Livingston S., M. D. (Formerly Medical Superintendent Essex County Hospital, Newark, N. J.)

Hitchcock, Chas. W., M. D., Attending Neurologist, Harper Hospital, Detroit, Mich.

Hobbs, Alfred T., M. D., Superintendent Homewood Sanitarium, Guelph, Ont.

Hoffman, Harry F., M. D., Assistant Superintendent, State Hospital, Allentown, Pa.

Holley, Erving, M. D., Senior Assistant Physician, Brooklyn State Hospital, Brooklyn, N. Y.

Houston, John A., M. D., Superintendent Northampton State Hospital, Northampton, Mass.

Howard, Eugene H., M. D., Medical Superintendent, Rochester State Hospital, Rochester, N. Y.

Hurd, Arthur W., M. D., Medical Superintendent Buffalo State Hospital, Buffalo, N. Y.

Hutchings, Richard H., M. D., Medical Superintendent St. Lawrence State Hospital, Ogdensburg, N. Y.

Hutchinson, Henry A., M. D., Physician and Superintendent, Dixmont Hospital for the Insane, Dixmont, Pa.

Isham, Mary Keyt, M. D., 135 W. 79th St., New York.

Jelliffe, Smith Ely, M. D., Consulting Neurologist Manhattan State Hospital, New York.

Jones, L. M., M. D., Superintendent Georgia State Sanitarium, Milledgeville, Ga.

Jones, Wm. A., M. D., Visiting Neurologist, Minneapolis City Hospital, Southside Sanitarium, Minneapolis, Minn.

Karpas, Morris J., M. D., Medical Examiner in Children's Court, New York Neurological Institute and Children's Court, New York.

Keating, Frank W., M. D., Medical Superintendent Rosewood State Training School, Owings Mills, Md.

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Kindred, John Joseph, M. D., Proprietor and Consultant, Rivercrest Sanitarium, Astoria, N. Y.

King, Geo. W., M. D., Medical Director Hudson County Hospital, Secaucus, N. J.

Kirby, Geo. H., M. D., Director Clinical Psychiatry, Manhattan State Hospital, Ward's Island, New York City.

Kline, Geo., M. D., Massachusetts Committee on Mental Diseases, Boston, Mass.

Klopp, Henry I., M. D., Superintendent and Physician-in-Chief, Homeopathic State Hospital, Allentown, Pa.

Knapp, John Rudolph, M. D., Assistant Physician Manhattan State Hospital, Ward's Island, New York City.

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LaMoure, Chas. T., M. D., Superintendent Connecticut Training School for Feeble-Minded, Lakeville, Conn.

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Landers, Geo. B., M. D., Superintendent Memorial Hospital, Morristown, N. J.

Lang, Walter E., M. D., Senior Assistant Physician, State Hospital, Allentown, Pa.

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Leahy, Sylvester R., M. D., Resident Alienist, Kings County Hospital, Brooklyn.

Leak, Roy L., M. D., Physician-in-Charge Syracuse Psychopathic Hospital, Syracuse, N. Y.

Lewis, J. M., M. D. (Formerly Superintendent Cleveland State Hospital, Cleveland, Ohio.)

Lind, John E., M. D., Senior Assistant Physician, St. Elizabeth's Hospital, Washington, D. C.

Locke, Hersey G., M. D., Associate Professor Psychiatry, Syracuse College of Medicine, Genesee Sanitarium, N. Y.

Long, T. L., M. D., First Assistant Physician, Northern Hospital, Winnebago, Wis.

McCampbell, John M., M. D., Superintendent State Hospital at Morgantown, Morgantown, N. C.

McDonald, Wm., Jr., M. D., 188 Blackstone Boulevard, Providence, R. I.

MacDonald, Carlos F., M. D., Physician-in-Charge Dr. MacDonald's House, 15 E. 48th St., New York City.

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Markham, C. L., M. D., Superintendent Brunswick Home, Amityville, N. Y.

May, James V., M. D., Superintendent Grafton State Hospital, North Grafton and Worcester, Mass.

Mellus, Edward, M. D., Superintendent Dr. Mellus' Private Hospital, Newton, Mass.

Meyer, Adolf, M. D., Psychiatrist-in-Chief, Henry Phipps' Psychiatric Clinic, Johns Hopkins Hospital, Baltimore, Md.

Miller, Henry W., M. D., Director "Mountainbrook," Brewster, N. Y.

Mitchell, H. W., M. D., Superintendent State Hospital for Insane, Warren, Pa.

Mitchell, J. C., M. D., Medical Superintendent Hospital for Insane, Brockville, Ont.

Moore, Arthur S., M. D., Senior Assistant Physician Middletown State Hospital, Middletown, N. Y.

Moore, J. W., M. D., First Assistant Physician, Matteawan State Hospital, Beacon, N. Y.

Mosher, J. M., M. D., Attending Specialist for Mental Diseases, Albany Hospital, Albany, N. Y.

Mullan, Eugene H., M. D., Public Health Service, Ellis Island, New York City.

Munson, J. F., M. D., Resident Pathologist Craig Colony for Epileptics, Sonyea (Mount Morris), N. Y.

Murdock, J. M., M. D., Superintendent State Institution for Feeble-Minded, Polk, Pa.

Newcomb, Philip B., M. D., Pathologist State Hospital, Bangor, Me.

North, Charles H., M. D., Medical Superintendent Dannemora State Hospital, Dannemora, N. Y.

O'Hanlon, George, M. D., General Medical Superintendent Bellevue and Allied Hospitals, New York.

O'Harrow, Marian, M. D., Assistant Physician Friends Hospital, Frankford, Philadelphia, Pa.

Orth, H. L., M. D., Superintendent and Physician Pennsylvania State Lunatic Hospital, Harrisburg, Pa.

Ostrander, Herman, M. D., Medical Superintendent Kalamazoo State Hospital, Kalamazoo, Mich.

Packer, Flavius, M. D., Physician-in-Charge, West Hill, Riverdale, New York City.

Page, Hartstein W., M. D., Formerly Superintendent Hospital Cottages for Children, Baldwinsville, Mass.

Palmer, H. L., M. D., Superintendent Utica State Hospital, Utica, N. Y.

Parker, Charles S., M. D., Assistant Physician Kings Park State Hospital, Kings Park, N. Y.

Patterson, C. J., M. D., Physician-in-Charge, Marshall Sanitarium, Troy, N. Y.

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Petery, Arthur K., M. D., First Assistant Physician, State Hospital for the Insane, Norristown, Pa.

Pilgrim, Charles W., M. D., Chairman State Hospital Commission, State of New York, Poughkeepsie, N. Y.

Potter, Clarence A., M. D., Superintendent Gowanda State Homeopathic Hospital, Collins, N. Y.

Priddy, A. S., M. D., Superintendent the State Epileptic Colony, Madison Heights, Va.

Prout, Thomas P., M. D., Superintendent Fair Oaks Sanitarium, Summit, N. J.

Purdum, H. D., M. D., Clinical Director, Springfield State Hospital, Sykesville, Md.

Putnam, Emma, M. D., Poughkeepsie, N. Y.

Raynor, Mortimer W., M. D., Chief Physician-Psychiatrist, Division of Reception and Classification, Department of Corrections, Penitentiary, Blackwell's Island, New York City.

Richardson, Wm. W., M. D., Medical Director The Mercer Sanitarium, Mercer, Pa.

Ripley, Horace G., M. D., Assistant Superintendent Taunton State Hospital, Taunton, Mass.

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Robinson, W. J., M. D., Medical Superintendent, Hospital for Insane, London, Ontario.

Rosanoff, A. J., M. D., First Assistant Physician Kings Park State Hospital, Kings Park, N. Y.

Ross, Donald L., M. D., Superintendent Connecticut Colony for Epileptics, Mansfield Depot, Conn.

Rowe, John T. W., M. D., First Assistant Physician, Manhattan State Hospital, Ward's Island, N. Y.

Ruggles, Arthur H., M. D., Assistant Physician, Butler Hospital, Providence, R. I.

Russell, William L., M. D., Medical Superintendent Bloomingdale Hospital, White Plains, N. Y.

Ryon, Dr. Walter G., M. D., Superintendent Hudson River State Hospital, Poughkeepsie, N. Y.

Sandy, William C., M. D., Assistant Superintendent Connecticut Hospital for Insane, Middletown, Conn.

Scribner, E. V., M. D., Medical Superintendent Worcester State Hospital, Worcester, Mass.

Searcy, J. D., M. D., Superintendent Alabama Insane Hospitals, Tuscaloosa, Ala.

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Shanahan, William T., M. D., Superintendent Craig Colony for Epileptics, Sonyea, N. Y.

Sharp, George A., M. D., Assistant Physician Matteawan State Hospital, Beacon, N. Y.

Shaw, Arthur L., M. D., Assistant Physician Craig Colony for Epileptics, Sonyea, N. Y.

Sheehan, Robert F., M. D., Navy Department, U. S. Naval Hospital, New York.

Singer, H. Douglas, M. D., Director State Psychopathic Institute, Kankakee, Ill.

Smith, G. A., M. D., Superintendent and Medical Director, Central Islip State Hospital, Central Islip, N. Y.

Smith, S. E., M. D., Medical Superintendent Eastern Indiana Hospital, Richmond, Ind.

Smith, Stephen, M. D. (Honorary), 300 Central Park West, New York.

Snavely, Earl H., M. D., Assistant Physician, Essex County Hospital, Cedar Grove, N. J.

Solomon, Harry C., M. D., Investigator Massachusetts Committee on Mental Diseases, Boston, Mass.

Somerville, William G., M. D., Memphis, Tenn.

Southard, Elmer E., M. D., Director Psychopathic Hospital, Boston, Mass.

Spaulding, Harry O., M. D., Superintendent Westborough State Hospital, Westborough, Mass.

Stack, S. S., M. D., Superintendent Sacred Heart Sanitarium and St. Mary's Hill Sanitarium, Milwaukee, Wis.

Stearns, A. W., M. D., Assistant Physician Psychopathic Hospital, Boston, Mass.

Steckel, Harry A., M. D., Assistant Physician Kings Park State Hospital, Kings Park, N. Y.

Stedman, Henry R., M. D., Superintendent Bournewood Hospital, South Street, Brookline, Mass.

Stick, H. Louis, M. D., Superintendent Hospital Cottages for Children, Baldwinsville, Mass.

Strecker, Edward A., M. D., Assistant Physician Pennsylvania Hospital, Philadelphia, Pa.

Swift, M. B., M. D., Psychopathic Department Boston State Hospital, Boston, Mass.

Terflinger, Frederick W., M. D., Medical Superintendent Northern Hospital for the Insane, Logansport, Ind.

Thom, Douglas A., M. D., Assistant Pathologist Massachusetts Commission on Mental Diseases, Grafton State Hospital, Worcester, Mass.

Thomas, John M., M. D., Superintendent Louisiana Hospital for the Insane, Pineville, La.

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Thompson, Charles E., Superintendent Gardner State Colony, Gardner, Mass.

Thompson, Whitefield N., M. D., Superintendent and Physician, Hartford Retreat, Hartford, Conn.

Thorne, Frederic H., M. D., Pathologist New Jersey State Hospital, Greystone, N. J.

Todd, Leona E., M. D., Woman Physician Hudson River State Hospital, Poughkeepsie, N. Y.

Toomey, Joseph H., M. D., Psychiatrist Police Psychopathic Laboratory, New York.

Treadway, Walter L., M. D., U. S. Public Health Service, Ellis Island, New York.

Turner, Reeve, M. D., Metropolitan Hospital, Blackwell's Island, New York.

Tuttle, George T., M. D., Medical Superintendent McLean Hospital, Waverley, Mass.

Toohey, John J., M. D., Physician-in-Charge Providence Retreat, Buffalo, N. Y.

Tyson, Dr. F. C., Superintendent Augusta State Hospital, Augusta, Me.

Van Nuys, W. C., M. D., Superintendent Indiana Village for Epileptics, Newcastle, Ind.

Wade, J. Percy, M. D., Medical Superintendent Spring Grove State Hospital, Catonsville, Md.

Wagner, Charles G., M. D., Superintendent Binghamton State Hospital, Binghamton, N. Y.

Walker, Eloise, M. D., Woman Physician Binghamton State Hospital, Binghamton, N. Y.

Walker, Lewis M., M. D., 100 W. 110th St., New York.

Webster, B. R., M. D., Assistant Physician Matteawan State Hospital, Beacon, N. Y.

Weeks, David F., M. D., Superintendent New Jersey State Village for Epileptics, Skillman, N. J.

Weston, Paul G., M. D., Pathologist State Hospital, Warren, Pa.

White, Wm. A., M. D., Superintendent Saint Elizabeth's Hospital, Washington, D. C.

Whitney, Ray L., M. D., Assistant Physician McLean Hospital, Waverley, Mass.

Wholey, C. C., M. D., West Pennsylvania Hospital, St. Francis Hospital, Pittsburgh, Pa.

Williams, C. F., M. D., Superintendent State Hospital for the Insane, Columbia, S. C.

Williams, Frankwood E., M. D., Associate Medical Director National Committee for Mental Hygiene, 50 Union Square, New York.

Wilsey, Orville J., M. D., Physician-in-Charge Long Island Home, Amityville, N. Y.

Witte, Max E., M. D., Superintendent Clarinda State Hospital, Clarinda, Iowa.

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Woodbury, Frank, M. D., Secretary Commission on Lunacy of Pennsylvania, Philadelphia, Pa.

Woodson, C. R., M. D., Superintendent and Physician-in-Charge C. R. Woodson Sanitarium, St. Joseph, Mo.

Woodman, Robert C., M. D., First Assistant Physician, Middletown State Homeopathic Hospital, Middletown, N. Y.

Woodward, Esther S. B., M. D., Psychiatrist Westchester County Clinic, Children's Division, White Plains, N. Y.

Work, Hubert, M. D., Superintendent Woodcroft Hospital, Pueblo, Col.

Wright, William W., M. D., Senior Assistant Physician Psychiatric Institute, Wards Island, New York.

The following visitors and guests of the Association registered their names with the Secretary.

Adams, Felix M., Superintendent East Oklahoma Hospital for the Insane, Vinita, Okla.

Allen, Mrs. J. Barton, Central Islip, N. Y.

Amsden, Mrs. G. S., White Plains, N. Y.

Armstrong, S. T., M. D., Physician-in-Charge, Kilbourn Club, Katonah, N. Y.

Baker, Benjamin W., Superintendent New Hampshire School for Feeble-Minded, Laconia, N. H.

Baker, Mrs. Benjamin W., Laconia, N. H.

Bancroft, Mrs. Chas. P., Concord, N. H.

Banks, Dr. Winifred D., East Orange, N. J.

Barlow, Mrs. Charles A., Spencer, W. Va.

Becker, W. F., M. D., Goldsmith Bldg., Milwaukee, Wis.

Beers, Clifford W., Secretary National Committee for Mental Hygiene, 50 Union Square, New York.

Beutler, Mrs. W. F., Wauwatosa, Wis.

Blew, Edgar Maule, M. D., Junior Assistant Physician State Hospital, Allentown, Pa.

Bond, J. B., M. D., Superintendent Western Hospital for the Insane, Bolivar, Tennessee.

Brink, Dr. Chas. G., New York City.

Brink, Mrs. C. G., New York City.

Broughton, Miss Liela E., New York City.

Brown, Mrs. D. L. Field W., Village for Epileptics, Skillman, N. J.

Brown, Miss Jessie L., Superintendent of Nurses, Pennsylvania Hospital, Philadelphia, Pa.

Brush, Mrs. Edward N., Towson, Baltimore Co., Md.

Buchanan, Mrs. J. M., Meridian, Miss.

Burgess, Mrs. T. J. W., Montreal, Que.

Burnett, Mrs. S. Grover, Kansas City, Mo.

Butler, Mrs. Thomas, Glen Cove, New York.

Capron, Mrs. Arthur J., Owego, N. Y.

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Cheney, Mrs. Clarence O., Ward's Island, New York.
Clark, Mrs. J. Henry, Newark, N. J.
Coffee, William L., Board of Administration, Milwaukee Co., Wauwatosa, Wis.
Cohoon, Mrs. E. H., Harding, Mass.
Conklin, Edwin G., Professor Biology, Princeton University, Princeton, N. J.
Cook, Mrs. Robert G., Brigham Hall, Canandaigua, N. Y.
Copp, Mrs. Owen, Philadelphia, Pa.
Corbett, M. J., Manager Binghamton State Hospital, Binghamton, N. Y.
Corbett, Mrs. M. J., Binghamton, N. Y.
Coyle, Miss Sarah, Village for Epileptics, Skillman, N. J.
Creighton, Mrs. J. B., Montreal, Que.
Davey, Miss May, East Orange, N. J.
Deady, Henderson B., M. D., Assistant Physician Neurological Institute, New York.
Donohoe, Mrs. George, Cherokee, Iowa.
Donett, John Victor, M. D., Physician New Jersey State Hospital, Greystone Park, N. J.
Donett, Mrs. J. V., Greystone Park, N. J.
Duke, John W., Chairman State Commission in Lunacy State of Oklahoma, Superintendent Duke Sanitarium, Guthrie, Okla.
Dunham, Sydney A., M. D., Private Sanitarium, Buffalo, N. Y.
Eastman, F. C., M. D., Brooklyn, N. Y.
Ellis, G. L., M. D., Superintendent Muierdale Sanatorium, Wauwatosa, Wis.
Elwood, Everett S., Secretary New York State Hospital Commission, Albany, N. Y.
Emerick, Mrs. E. J., Columbus, Ohio.
Eyman, Miss Ethel, Matron Massillon State Hospital, Massillon, Ohio.
Farmer, Winfield Scott, M. D., Superintendent Central Hospital for Insane, Nashville, Tenn.
Farrington, Lewis M., Assistant Secretary and Treasurer, New York State Hospital Commission, Albany, N. Y.
Fisher, Mrs. E. Moore, Graystone Park, N. J.
Forster, Mrs. J. M., Toronto, Ont.
Gahagan, H. J., M. D., Superintendent Elgin State Hospital, Elgin, Ill.
Garvin, Mrs. W. C., Kings Park, N. Y.
Gaston, E. P., New York.
Ginane, M. A., Matron S. P. C. C., Brooklyn, N. Y.
Gibbons, Mrs. Amos J., Stamford, Conn.
Guichtel, A. Lawrence, M. D., New York.
Haines, Emily L., Boston, Mass.
Hamilton, Mrs. S. W., New York City.
Hammond, Graeme M., Professor Mental and Nervous Diseases New York Post Graduate and Hospital, New York.

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Hastings, George A., Executive Secretary Mental Hygiene Committee, N. Y. State Charities Aid Association, New York.

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Hebin, Mrs. Carl J., Maine School for Feeble-Minded, West Pownal, Maine.

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Herr, Daniel C., Member Board of Trustees Pennsylvania State Lunatic Hospital, Harrisburg, Pa.

Heyen, John P., M. D., Manager Kings Park State Hospital, Northport, N. Y.

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Kieb, Mrs. Raymond F. C., Beacon, N. Y.

Kindred, Mrs. John Joseph, Astoria, L. I.

Klopp, Mrs. Henry I., Allentown, Pa.

Kolb, Lawrence, Public Health Service, Ellis Island, New York.

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LaMoure, Mrs. Charles T., Lakeville, Conn.

Leszynsky, William M., M. D., Neurologist Harlem Hospital, Lebanon Hospital, New York.

Levy, Louis Spencer, New York.

Lemelson, Julius, Stapleton, S. I., N. Y.

Lewis, Mrs. J. M., Cleveland, Ohio.

Lubin, Edward K., New York City.

Main, Daniel C., M. D., Welaka, Fla.

May, Mrs. James V., North Grafton, Mass.

McCarty, Charles W., New York City.

MacDonald, Miss Elizabeth H., Brooklyn, N. Y.

MacDonald, Mrs. Wm., Jr., Providence, R. I.

McGarr, T. E., Reporter of Association, Albany, N. Y.

McGarr, Mrs. T. E., Albany, N. Y.

McNairy, C. Banks, M. D., Superintendent Training School, State Institution for Mental Defectives, Kingston, N. C.

McPherson, John, M. D., Medical Officer, Tampico, Mexico.

Messmer, Robert A., Milwaukee, Wis.

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Miller, S. M., Chief Resident Physician State Hospital for Insane, Norristown, Pa.

Miller, Thurlow S., St. Francis Hospital, San Francisco, Cal.

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Moosbrugger, Mrs. Herman F., Somerville, N. J.
Morgan, A. D., State Hospital Commissioner, Ilion, N. Y.
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Murphy, William A., New York City.
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Richardson, Mrs. W. W., Mercer, Pa.
Riley, John J., Inspector State Hospital Commission, Albany, N. Y.
Robinson, Leigh F., M. D., Assistant Surgeon U. S. N., Hartford, Conn.
Robinson, Miss Ruth, Hospital for Insane, London, Ont.
Robinson, Mrs. W. J., Hospital for Insane, London, Ont.
Rosanoff, Mrs. A. J., Kings Park, N. Y.
Russell, Mrs. Wm. L., Bloomingdale Hospital, White Plains, N. Y.
Rutherford, Thomas A., M. D., Superintendent Hillside Home, Clark Summit, Pa.
Ryon, Mrs. Walter G., Poughkeepsie, N. Y.
St. George, A. V., M. D., Pathologist, Bellevue Hospital, New York.
Sampsell, Ward, M. D., First Assistant Physician, Rivercrest Sanitarium, Astoria, N. Y.
Sautter, C. M., M. D., 11 E. 48th St., New York.

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Saxe, Josef, New York.

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Schneid, Alwin J., State Charities Aid Association, New York.

Schorer, Cornelia B. J., Psychiatrist Laboratory of Social Hygiene, Bedford Hills, N. Y.

Schroeder, Theodore, Cos Cob, Conn.

Scofield, Ethel Lord, Field Worker New Haven, Conn.

Scribner, Mrs. E. V., Worcester State Hospital, Worcester, Mass.

Silberg, Charles, Brooklyn.

Slaughter, Mildred, Research Worker Essex County Hospital, Cedar Grove, N. J.

Slawson, Miss Jean, New York.

Smalley, Evelyn Y., Research Department, National Committee for Mental Hygiene, New York.

Smith, Carolyn, Instructor in Occupation, Philadelphia, Pa.

Smith, Mrs. George A., Central Islip, N. Y.

Smith, Susan C., Central Islip, N. Y.

Smith, MacGregor Jas., President Board of Managers, Central Islip State Hospital, Central Islip, New York.

Smith, Mrs. James MacGregor, New York.

Smith, Mrs. S. E., East Haven, Richmond, Ind.

Smith, Walter J., New York.

Smith, Mrs. Walter J., New York.

Solomon, Abraham, New York.

Stack, Mrs. S. S., Milwaukee, Wis.

Stoneaker, C. L., Secretary New Jersey State Charities Aid Association, Newark, N. J.

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Streeter, F. D., M. D., Assistant Physician State Hospital, Central Islip, N. Y.

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Thomas, Heyward G., Oakland, Cal.

Thomas, Mrs. John W., Matron Louisiana Hospital for Insane, Pineville, La.

Thompson, George L., Kings Park, N. Y.

Throckmorton, J. W., Brooklyn, N. Y.

Tracy, Samuel G., M. D., Bellevue Hospital, New York.

Tuttle, Mrs. Geo. T., McLean Hospital, Waverley, Mass.

Toohey, Mrs. John J., Buffalo, N. Y.

Wagner, Mrs. Charles G., Binghamton, N. Y.

Weeks, Mrs. David F., Skillman, N. J.

Wholey, Mrs. C. C., Pittsburgh, Pa.

Widen, Luther E., Consulting Psychologist, New York.

Whitney, Mrs. Ray L., McLean Hospital, Waverley, Mass.

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Wilde, Walter J., Member Board of Administration, Milwaukee County, Milwaukee, Wis.

Winslow, Paul V., M. D., Brooklyn, N. Y.

Young, Albert F., M. D., Superintendent Milwaukee Hospital for the Insane, Milwaukee, Wis.

Afternoon Session.

The Association reconvened at 2.45 p. m.

The President.—Before proceeding with the literary program we will have the report of the Committee on Statistics. Dr. Salmon, Chairman of the committee, is in France, and Dr. Copp will make a preliminary report at this time. I would also announce that I have added to this committee Dr. L. Vernon Briggs of Boston.

Dr. Copp.—*Mr. President, Ladies and Gentlemen:* This report was printed and sent to every member of the Association. If anyone has failed to receive it, a copy can be had here at the Secretary's desk. I am assuming that every one has received and also read the report, but this may be a hazardous conclusion; and so it has been suggested that discussion on the report be postponed to some later period in our meeting. At this time I will present the report for your consideration.

REPORT OF THE COMMITTEE ON STATISTICS OF THE AMERICAN MEDICO-PSYCHOLOGICAL ASSOCIATION.

To the American Medico-Psychological Association:

Your Committee on Statistics since its original appointment at the Niagara Falls meeting in 1913 has held several meetings and has carefully considered the following topics:

1. The desirability of uniform statistics relative to mental diseases and the operation of institutions for the insane.
2. The classification of mental diseases.
3. Forms to be used in reporting statistical data.
4. Means to be adopted to secure uniform statistical reports.

1. The Desirability of Uniform Statistics Relative to Mental Diseases and the Operation of Institutions for the Insane.

That the statistical data annually compiled by the various institutions for the insane throughout the country should be uniform in plan and scope is no longer open to question. The lack of such uniformity makes it absolutely impossible at the present time to collect comparative statistics concerning mental diseases in different states and countries, and extremely difficult to secure comparative data relative to movement of patients, administration, and cost of maintenance and additions. The importance and need of some system whereby uniformity in reports would be secured have been repeatedly emphasized by officers and members of this Association, by statisticians of

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the United States Census Bureau, by editors of psychiatric journals, and by administrative officials in various states. We should know accurately the forms of mental disease occurring in all parts of the country; we should know the movement of patients in every hospital for the insane; we should know the cost of maintenance of patients and the amounts spent for additions and improvements in every state hospital; we should be able to compile annually complete data concerning these and other matters, and compute rates and draw comparisons therefrom. Such data would serve as the basis for constructive work in raising the standard of care of the insane, as a guide for preventive effort, and as an aid to the progress of psychiatry.

2. The Classification of Mental Diseases.

Your committee feels that the first essential of a uniform system of statistics in hospitals for the insane is a generally recognized nomenclature of mental diseases. The present condition with respect to the classification of mental diseases is chaotic. Some states use no well-defined classification. In others the classifications used are similar in many respects but differ enough to prevent accurate comparisons. Some states have adopted a uniform system, while others leave the matter entirely to the individual hospitals. This condition of affairs discredits the science of psychiatry and reflects unfavorably upon our Association, which should serve as a correlating and standardizing agency for the whole country.

The large task of your committee therefore has been the formulation of a classification which it could unanimously recommend for adoption by the Association. The task was accomplished only after several prolonged conferences at which classifications now in use in various states and countries, and the recommendations of leading psychiatrists were considered. The classification finally adopted is simple, comprehensive and complete; it copies no other classification but includes the strong features of many others; it meets the demands of the best modern psychiatry but does not slavishly follow any single system. In short, your committee has endeavored to formulate a classification that could be easily used in every hospital for the insane in this country and that would meet the scientific demands of the present day.

The following is the classification submitted for your approval:

Proposed Classification of Mental Diseases.

1. Traumatic psychoses.
2. Senile psychoses.
   - (a) Simple deterioration.
   - (b) Presbyophrenic type.
   - (c) Delirious and confused states.
   - (d) Depressed and agitated states in addition to deterioration.
   - (e) Paranoid states in addition to deterioration.
3. Psychoses with cerebral arteriosclerosis.*

* This includes psychoses following cerebral hemorrhage.

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4. General paralysis.
5. Psychoses with cerebral syphilis.
6. Psychoses with Huntington's chorea.
7. Psychoses with brain tumor.
8. Psychoses with other brain or nervous diseases.

The following are the more frequent diseases to be specified when possible:

Cerebral embolism.
Paralysis agitans.
Tubercular or other forms of meningitis (to be specified).
Multiple sclerosis.
Tabes.
Acute chorea.
Other conditions (to be specified).

9. Alcoholic psychoses.
   (a) Pathological intoxication.
   (b) Delirium tremens.
   (c) Acute hallucinosis.
   (d) Acute paranoid type.
   (e) Korsakow's psychosis.
   (f) Chronic hallucinosis.
   (g) Chronic paranoid type.
   (h) Alcoholic deterioration.
   (i) Other types, acute or chronic.
10. Psychoses due to drugs and other exogenous toxins.
   (a) Morphine, cocaine, bromides, chloral, etc., alone or combined (to be specified).
   (b) Metals, as lead, arsenic, etc. (to be specified).
   (c) Gases (to be specified).
   (d) Other exogenous toxins (to be specified).
11. Psychoses with pellagra.
12. Psychoses with other somatic diseases.
   (a) Delirium with infectious diseases.
   (b) Post-infectious psychoses.
   (c) Exhaustion delirium.
   (d) Delirium of unknown origin.
   (e) Diseases of the ductless glands.
   (f) Cardio-renal disease.
   (g) Cancer.
   (h) Other diseases or conditions (to be specified).
13. Manic-depressive psychoses.
   (a) Manic type
   (b) Depressive type.
   (c) Stupor.
   (d) Mixed type.
   (e) Circular type.
14. Involution melancholia.

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15. Dementia præcox.
    (a) Paranoid type.
    (b) Katatonic type.
    (c) Hebephrenic type.
    (d) Simple type.
16. Paranoia and paranoic conditions.
17. Psychoneuroses.
    (a) Hysterical type.
    (b) Psychasthenic type.
    (c) Neurasthenic type.
18. Psychoses with mental deficiency.
19. Psychoses with constitutional psychopathic inferiority.
20. Epileptic psychoses.
    (a) Deterioration.
    (b) Clouded states.
    (c) Other conditions (to be specified).
21. Undiagnosed psychoses.
22. Not insane.
    (a) Epilepsy without psychosis..
    (b) Alcoholism without psychosis.
    (c) Drug addiction without psychosis.
    (d) Constitutional psychopathic inferiority without psychosis.
    (e) Mental deficiency without psychosis.
    (f) Others (to be specified).

3. Forms to be Used in Reporting Statistical Data.

Your committee appends hereto a series of forms for uniform reports from institutions for the insane and recommends their adoption by the Association. The forms provide for reports of data that should be annually compiled by every hospital for the insane and that should be available for use by everyone interested in psychiatry or the treatment of mental diseases.

The following is the list of forms recommended:

Form 1. General information.
Form 2. Financial statement.
Form 3. Movement of patients.
Form 4. Nativity and parentage of first admissions.
Form 5. Citizenship of first admissions.
Form 6. Psychoses of first admissions, types as well as principal psychoses to be designated.
Form 7. Race of first admissions classified with reference to principal psychoses.
Form 8. Age of first admissions classified with reference to principal psychoses.
Form 9. Degree of education of first admissions classified with reference to principal psychoses.

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Form 10. Environment of first admissions classified with reference to principal psychoses.
Form 11. Economic condition of first admissions classified with reference to principal psychoses.
Form 12. Use of alcohol by first admissions classified with reference to principal psychoses.
Form 13. Marital condition of first admissions classified with reference to principal psychoses.
Form 14. Psychoses of readmissions, types as well as principal psychoses to be designated.
Form 15. Discharges of patients classified with reference to principal psychoses and condition on discharge.
Form 16. Causes of death of patients classified with reference to principal psychoses.
Form 17. Age of patients at time of death classified with reference to principal psychoses.
Form 18. Duration of hospital life of patients dying in hospital, classified with reference to psychoses.

4. Means to be Adopted to Secure Uniform Statistical Reports from all Hospitals for the Insane.

The first great step toward securing uniform statistical reports from all hospitals for the insane is the adoption by this Association of a classification of mental diseases and a series of forms for statistical tables. The second step will consist in making provision for the annual collection of data from hospitals throughout the country, and the publication of an annual statistical review for distribution to members of this Association. Your committee believes that such statistical work should be conducted by this Association through a committee on statistics who would employ a trained statistician to have direct charge of the collection and tabulation of the reports from the several hospitals. The National Committee for Mental Hygiene has kindly offered to co-operate in this work by tendering the use of its statistical office to the Association. The estimated annual expense of the statistical work contemplated, including printing and postage, would be approximately $1800. The amount is insignificant compared with the great importance of the work to this Association, to psychiatry, to administrative officials, and to the vast army of mental sufferers.

Your committee would recommend the appointment of a standing committee on statistics, and that such committee be authorized to conduct for the Association the statistical work herein outlined during the ensuing year, and to secure, if possible, the adoption of the Association's classification of mental diseases by federal and state authorities.

The committee desires especially to record its appreciation of the valuable aid rendered by Dr. August Hoch, Director of the Psychiatric Institute of the New York State Hospitals, and Dr. Horatio M. Pollock, Statistician,

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New York State Hospital Commission. These gentlemen have given very fully of their time and their experience.

Respectfully submitted,

THOMAS W. SALMON,
OWEN COPP,
JAMES V. MAY,
E. STANLEY ABBOT,
HENRY A. COTTON,
Committee on Statistics.

FORMS.

EXPLANATORY NOTE.

The forms recommended by the committee are submitted herewith in outline with brief explanatory notes; if adopted by the Association they will be printed and ruled in proper form and distributed to the co-operating hospitals. In order to secure uniformity in filling out the blanks, a booklet of directions will be prepared and sent with the forms to the hospitals.

Form 1.

GENERAL INFORMATION.

Relating to.....Hospital.
Located at.....city or postoffice.....State.
Date correct *at end* institution year....., 19...., unless otherwise specified.

1. Date of opening as an institution for the insane..... .....
2. Type of institution: State, county, city, endowed private, or unendowed private?..... .....
3. Hospital plant:
   - Value of hospital property..... .....
   - Real estate including buildings..... .....
   - Personal property ....
   - Total ....
   - Total acreage of hospital property*..... .....
   - Acreage under cultivation during year..... .....

4. Medical service:	Men.	Women.	Total.
Superintendents	.....	.....	.....
Assistant physicians	.....	.....	.....
Medical internes	.....	.....	.....
Clinical assistants	.....	.....	.....
Total	.....	.....	.....

5. Employees:†	Males.	Females.	Total.
Graduate nurses	.....	.....	.....
Other nurses and attendants	.....	.....	.....
Social workers	.....	.....	.....
All other employees	.....	.....	.....
Total	.....	.....	.....

6. Percentage of patients employed during year	Men.	Women.	Total.
	.....	.....	.....

* Includes grounds, farm and garden and sites occupied by buildings.
† Not including physicians.

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Form 2.

FINANCIAL STATEMENT.

.....Hospital.
Located at.....city or postoffice.....State.
For the fiscal year ended....., 19....

RECEIPTS.

1. For maintenance of patients:	
Balance on hand from previous fiscal year.....	.....
From appropriations	.....
From paying patients.....	.....
From all other sources.....	.....
Total receipts for maintenance.....	.....
2. For all purposes other than maintenance, including new buildings, additions, improvements, etc.:	
Balance on hand from previous fiscal year.....	.....
From all other sources	.....
Total receipts	.....

DISBURSEMENTS.

1. Expenditures for maintenance of patients:	
(Under this heading should be included, as outlined in the ten subheads, all items covering maintenance of patients as such, and of plant, *i. e.*, supplies and repairs intended to keep the plant in its present condition or to restore it to its former condition.)	
Salaries and wages.....	.....
Provisions	.....
Farm and garden.....	.....
Clothing	.....
Furniture and furnishings.....	.....
Fuel and light.....	.....
Ordinary repairs and shops.....	.....
Medical supplies	.....
Transportation of patients.....	.....
Miscellaneous, including general supplies, lawns, roads, grounds, etc.	.....
Total expenditures for maintenance.....	.....
2. Expenditures for all purposes other than maintenance, including new buildings, additions, improvements, etc.	.....
(Under this heading should be placed all expenditures for items, such as additional land [bought or reclaimed], new buildings, new equipment [not replacements], etc., which represent, not restorations, but improvements or additions to plant.)	
Total expenditures	.....
Amount returned to state treasurer or other officials	.....
Balance on hand at close of year.....	.....
(Includes balance for maintenance and for all other purposes.)	
Total disbursements, including balance on hand...	.....
(This item should equal total receipts.)	

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Form 3.

Movement of Insane Patient Population.

For year beginning.....and ending.....
in the.....Hospital.

Located at.....

Includes all admitted insane patients on books of institution regardless of the method of admission, whether voluntary, committed, emergency, temporary care, for observation or otherwise; but does not include those who are *only* dispensary or out-patient cases.

	Cases.		
	Males.	Females.	Total.
1. Insane patients on books of institution at beginning of institution year	.....	.....	.....
(Includes patients away from institution on parole, boarded out, on visit, and escaped, but still on books.)			
Admissions during year:			
a. First admissions	.....	.....	.....
(Includes all insane patients admitted for the first time to *any* institution for the insane, public or private, wherever situated, in or outside of state, excepting institutions for temporary care only.)			
b. Readmissions	.....	.....	.....
(Includes all insane patients admitted who have been previously under treatment in an institution for the insane, excepting transfers, [c], and patients who have received treatment only in institutions for temporary care only [a]).			
Total admissions	.....	.....	.....
c. Transfers from other institutions for the insane.....	.....	.....	.....
(Includes all insane patients coming directly from any other institution for the insane, public or private, in same state, excepting institutions for temporary care.)			
2. Total received during year.....	.....	.....	.....
(Includes total of items a, b, c.)			
3. Total under treatment during year...	.....	.....	.....
(Includes total of items 1 and 2.)			
Discharged from books during year:			
(Does not include patients away from institution on parole, on visit, boarded out or on other temporary leave from hospital. Escapes when discharged should be included in a, b, c or d, according to condition when escape occurred.)			
a. As recovered	.....	.....	.....

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b. As improved ....
(Does not include transfers.)

c. As unimproved ....
(Includes all insane patients discharged not benefited by treatment, exclusive of transfers.)

d. As not insane..... ....
(Includes all discharged patients who though admitted as insane are found to have had no psychosis.)

e. Transferred to other institutions for the insane..... ....
(Includes all insane patients sent directly to any other institution for the insane, public or private, in same state, excepting institutions for temporary care.)

f. Died during year..... ....

4. Total discharged from books during year ....
(Includes total of items a, b, c, d, e and f.)

5. Insane patients remaining on books of institution at end of institution year ....
(Includes patients away from institutions on parole, boarded out, on visit and escaped.)
This total should equal total under treatment (3) less discharges (4).

SUPPLEMENTARY DATA.

6. Average daily number of insane patients actually in the institution during year..... ....

7. Average daily number of other insane patients on books, but away from institution on parole, on visit, boarded out, escaped, or on temporary leave..... ....

8. Number of insane voluntary patients admitted during year..... ....

9. Number of non-insane patients or inmates in institution at end of institution year:
a. Drug cases ....
b. Inebriates ....
c. Neurological cases ....
d. Epileptics (not feeble-minded) ....
e. Feeble-minded cases (not epileptics) ....
f. Feeble-minded epileptics ....
g. All other cases..... ....
h. Persons given advice or treatment in out-patient departments during year..... ....

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Form 4.

.....Hospital.

NATIVITY OF FIRST ADMISSIONS AND OF PARENTS OF FIRST ADMISSIONS, YEAR ENDING.....

Nativity.	Patients. M. F. T.	Parents of male patients M. F. T.	Parents of female patients. M. F. T.
United States			
Africa			
Asia *			
Atlantic Islands			
Australia			
Austria			
Belgium			
Bohemia			
Canada †			
Central America			
China			
Cuba			
Denmark			
England			
Europe ‡			
Finland			
France			
Germany			
Greece			
Hawaii			
Holland			
Hungary			
India			
Ireland			
Italy			
Japan			
Mexico			
Norway			
Philippine Islands			
Poland			
Porto Rico			
Portugal			
Roumania			
Russia			
Scotland			
South America			
Spain			
Sweden			
Switzerland			
Turkey in Asia			
Turkey in Europe			
Wales			
West Indies §			
Other countries			
Born at sea			
Total foreign born			
Unascertained			
Grand total			

(Form to be ruled.)

* Not otherwise specified.
† Includes Newfoundland.
‡ Not otherwise specified.
§ Except Cuba and Porto Rico.

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Form 5.

.....Hospital.

CITIZENSHIP OF FIRST ADMISSIONS.

	Males.	Females.	Total.
Citizens by birth.....	.....	.....	.....
Citizens by naturalization *.....	.....	.....	.....
Aliens	.....	.....	.....
Citizenship unascertained	.....	.....	.....
Total	.....	.....	.....

Form 6.

.....Hospital.

PSYCHOSES OF FIRST ADMISSIONS.

Psychoses.	Males.	Females.	Total.
1. Traumatic	.....	.....	.....
2. Senile, total	.....	.....	.....
(a) Simple deterioration	.....	.....	.....
(b) Presbyophrenic type	.....	.....	.....
(c) Delirious and confused states	.....	.....	.....
(d) Depressed and agitated states in addition to deterioration	.....	.....	.....
(e) Paranoid states in addition to deterioration	.....	.....	.....
3. With cerebral arteriosclerosis.....	.....	.....	.....
4. General paralysis	.....	.....	.....
5. With cerebral syphilis.....	.....	.....	.....
6. With Huntington's chorea.....	.....	.....	.....
7. With brain tumor.....	.....	.....	.....
8. With other brain or nervous diseases, total	.....	.....	.....
Cerebral embolism	.....	.....	.....
Paralysis agitans	.....	.....	.....
Tubercular or other forms of meningitis	.....	.....	.....
Multiple sclerosis	.....	.....	.....
Tabes	.....	.....	.....
Acute chorea	.....	.....	.....
Other conditions	.....	.....	.....
9. Alcoholic, total	.....	.....	.....
(a) Pathological intoxication	.....	.....	.....
(b) Delirium tremens	.....	.....	.....
(c) Acute hallucinosis	.....	.....	.....
(d) Acute paranoid type.....	.....	.....	.....
(e) Korsakow's psychosis	.....	.....	.....
(f) Chronic hallucinosis	.....	.....	.....
(g) Chronic paranoid type.....	.....	.....	.....
(h) Alcoholic deterioration	.....	.....	.....
(i) Other types, acute or chronic	.....	.....	.....
10. Due to drugs and other exogenous toxins, total	.....	.....	.....
(a) Morphine, cocaine, bromides, chloral, etc., alone or combined	.....	.....	.....

* Includes naturalization by. court, marriage and by naturalization of parent or husband.

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(b) Metals, as lead, arsenic, etc...	.....	.....	.....
(c) Gases	.....	.....	.....
(d) Other exogenous toxins.....	.....	.....	.....
11. With pellagra	.....	.....	.....
12. Psychoses with other somatic diseases, total	.....	.....	.....
(a) Delirium with infectious diseases	.....	.....	.....
(b) Post-infectious psychoses	.....	.....	.....
(c) Exhaustion delirium	.....	.....	.....
(d) Delirium of unknown origin..	.....	.....	.....
(e) Diseases of the ductless glands	.....	.....	.....
(f) Cardio-renal disease	.....	.....	.....
(g) Cancer	.....	.....	.....
(h) Other diseases or conditions (to be specified)	.....	.....	.....
13. Manic-depressive, total	.....	.....	.....
(a) Manic type	.....	.....	.....
(b) Depressive type	.....	.....	.....
(c) Stupor	.....	.....	.....
(d) Mixed type	.....	.....	.....
(e) Circular type	.....	.....	.....
14. Involution melancholia	.....	.....	.....
15. Dementia præcox, total.....	.....	.....	.....
(a) Paranoid type	.....	.....	.....
(b) Katatonic type	.....	.....	.....
(c) Hebephrenic type	.....	.....	.....
(d) Simple type	.....	.....	.....
16. Paranoia and paranoic conditions...	.....	.....	.....
17. Psychoneuroses, total	.....	.....	.....
(a) Hysterical type	.....	.....	.....
(b) Psychasthenic type	.....	.....	.....
(c) Neurasthenic type	.....	.....	.....
18. With mental deficiency.....	.....	.....	.....
19. With constitutional psychopathic inferiority	.....	.....	.....
20. Epileptic, total	.....	.....	.....
(a) Deterioration	.....	.....	.....
(b) Clouded states	.....	.....	.....
(c) Other conditions	.....	.....	.....
21. Undiagnosed	.....	.....	.....
22. Not insane, total.....	.....	.....	.....
(a) Epilepsy without psychosis...	.....	.....	.....
(b) Alcoholism without psychosis	.....	.....	.....
(c) Drug addiction without psychosis	.....	.....	.....
(d) Constitutional psychopathic inferiority without psychosis..	.....	.....	.....
(e) Mental deficiency without psychosis	.....	.....	.....
(f) Others	.....	.....	.....

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Form 7.

.....Hospital.

RACE OF FIRST ADMISSIONS CLASSIFIED WITH REFERENCE TO PSYCHOSES.

Race.	Psychoses. Total M. F. T.	(Separate columns will be provided for each principal group of psychoses from 1 to 22.)
African (black)		
American Indian		
Armenian		
Bulgarian		
Chinese		
Cuban		
Dutch and Flemish		
East Indian		
English		
Finnish		
French		
German		
Greek		
Hebrew		
Irish		
Italian *		
Japanese		
Korean	(Form to be ruled.)	
Lithuanian		
Magyar		
Mexican		
Pacific Islander		
Portuguese		
Roumanian		
Scandinavian †		
Scotch		
Slavonic ‡		
Spanish		
Spanish American		
Syrian		
Turkish		
Welsh		
West Indian §		
Other specific races		
Mixed		
Race unascertained		
Total		

* Includes "North" and "South."
† Norwegians, Danes and Swedes.
‡ Includes Bohemian, Bosnian, Croatian, Dalmatian, Herzegovinian, Montenegrin, Moravian, Polish, Russian, Ruthenian, Slovak, Slovenian.
§ Except Cuban.

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Form 8.

.....Hospital.

AGE OF FIRST ADMISSIONS CLASSIFIED WITH REFERENCE TO PRINCIPAL PSYCHOSES.

Psychoses.	Total. M. F. T.	Under 15 years M. F. T.	Separate columns will be provided for each quinquennial age group from 15 to 80 years.
1. Traumatic			
2. Senile			
3. With cerebral arteriosclerosis			
4. General paralysis			
5. With cerebral syphilis			
6. With Huntington's chorea			
7. With brain tumor			
8. With other brain or nervous diseases			
9. Alcoholic			
10. Due to drugs and other exogenous toxins			
11. With pellagra	(Form to be ruled.)		
12. With other somatic diseases			
13. Manic-depressive			
14. Involution melancholia			
15. Dementia præcox			
16. Paranoia and paranoic conditions			
17. Psychoneuroses			
18. With mental deficiency			
19. With constitutional psychopathic inferiority			
20. Epileptic			
21. Undiagnosed			
22. Not insane			

Form 9.

.....Hospital.

DEGREE OF EDUCATION OF FIRST ADMISSIONS CLASSIFIED WITH REFERENCE TO PSYCHOSES.

Psychoses.	Total. M. F. T.	Illiterate. M. F. T.	Reads and writes. M. F. T.	Common School. M. F. T.	High School. M. F. T.	College. M. F. T.	Unascertained. M. F. T.
(Names of principal psychoses to be inserted as in Form 8.)	(Form to be ruled.)						

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Form 10.

.....Hospital.

ENVIRONMENT OF FIRST ADMISSIONS CLASSIFIED WITH REFERENCE TO PRINCIPAL PSYCHOSES.

Psychoses.	Total. M. F. T.	Urban. M. F. T.	Rural. M. F. T.	Unascertained. M. F. T.
(Names of principal psychoses to be inserted as in Form 8.)	(Form to be ruled.)			

Form 11.

.....Hospital.

ECONOMIC CONDITION OF FIRST ADMISSIONS CLASSIFIED WITH REFERENCE TO PRINCIPAL PSYCHOSES.

Psychoses.	Total. M. F. T.	Dependent. M. F. T.	Marginal. M. F. T.	Comfortable. M. F. T.	Unascertained. M. F. T.
(Names of principal psychoses to be inserted as in Form 8.)	(Form to be ruled.)				

Form 12.

.....Hospital.

USE OF ALCOHOL BY FIRST ADMISSIONS CLASSIFIED WITH REFERENCE TO PRINCIPAL PSYCHOSES.

Psychoses.	Total. M. F. T.	Abstinent. M. F. T.	Temperate. M. F. T.	Intemperate. M. F. T.	Unascertained. M. F. T.
(Names of principal psychoses to be inserted as in Form 8.)	(Form to be ruled.)				

Form 13.

.....Hospital.

MARITAL CONDITION OF FIRST ADMISSIONS CLASSIFIED WITH REFERENCE TO PRINCIPAL PSYCHOSES.

Psychoses.	Total. M. F. T.	Single. M. F. T.	Married. M. F. T.	Widowed. M. F. T.	Separated. M. F. T.	Divorced. M. F. T.	Unascertained. M. F. T.
(Names of principal psychoses to be inserted as in Form 8.)	(Form to be ruled.)						

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Form 14.

.....Hospital.

PSYCHOSES OF READMISSIONS.

(Same form as Form 6, "Psychoses of first admissions.")

Form 15.

.....Hospital.

DISCHARGES OF PATIENTS CLASSIFIED WITH REFERENCE TO PRINCIPAL PSYCHOSES AND CONDITION OF DISCHARGE.

Psychoses.	Total. M. F. T.	Recovered. M. F. T.	Improved. M. F. T.	Unimproved. M. F. T.	Not insane. M. F. T.
(Names of principal psychoses to be inserted as in Form 8.)	(Form to be ruled.)				

Form 16.

.....Hospital.

CAUSES OF DEATH OF PATIENTS CLASSIFIED WITH REFERENCE TO PRINCIPAL PSYCHOSES.

Cause of death.	Total.
(Diseases to be inserted in accordance with international list as used in U. S. Public Health Service.)	(Insert names of principal psychoses with subdivisions by sex as in Form 7.)
(Form to be ruled.)	

Form 17.

.....Hospital.

AGE OF PATIENTS AT TIME OF DEATH CLASSIFIED WITH REFERENCE TO PRINCIPAL PSYCHOSES.

(Same form as Form 8.)

(Form to be ruled.)

Form 18.

.....Hospital.

TOTAL DURATION OF HOSPITAL LIFE OF PATIENTS DYING IN HOSPITAL CLASSIFIED ACCORDING TO PYSCHOSES.

Psychoses.	Total. M. F. T.	Less than 1 month. M. F. T.	1-3 months. M. F. T.	4-7 months. M. F. T.	8-12 months. M. F. T.	1-2 years. M. F. T.	3-4 years. M. F. T.
(Additional periods to be added.)							
(Names of principal psychoses to be inserted as in Form 8.)	(Form to be ruled.)						

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THE PRESIDENT.—Agreeably to Dr. Copp's request, all action on the report will be left to a later meeting.

We will now proceed to the literary program, the first paper of the afternoon being "A Wider Field of Activity for the Association," by Dr. James V. May.

At the close of Dr. May's paper, the President announced that discussion was in order.

Dr. May's paper was discussed by Drs. Stedman, Wm. A. White, Gershom Hill, F. W. Robertson, Copp, Blumer, Work, MacDonald, Wm. A. Jones, Carmichael and Dr. May in closing.

THE PRESIDENT.—The next paper will be "The Influence of Great Wars on Thought and Progress," by Dr. Charles K. Mills, and Dr. T. H. Weisenburg of Philadelphia.

DR. MILLS.—Mr. President, I might say as an introductory note, that as this paper was originally planned it was intended to be in two parts; one relating to the psychology of war, which was assigned to me, and the other on material progress as illustrated by the present and perhaps other wars. This was to have been taken up by Dr. Weisenburg. He has been prevented by circumstances from coming to the meeting and therefore it was decided between us that I should simply present what might be termed the psychology of the present war. It may be thought perhaps by some of those present that this subject is one not strictly of a medical character, and therefore, it may be somewhat frowned upon by those who would have us adhere strictly to psychiatry. Nevertheless, the psychology of war is largely a morbid psychology and in so far as it is this, its study certainly must be a source of illumination to the psychiatrist. I shall present this paper practically in the abstract, giving it greater length when it comes to be presented for publication.

Dr. Mills then read his paper in abstract.

THE PRESIDENT.—Dr. Mills' paper is before the Association for discussion. It is an exceedingly interesting paper and I would be glad to hear from any member who desires to discuss it.

DR. DERLIN.—Mr. President, I have no intention of discussing the paper of the last distinguished speaker, but simply desire to say a few words on a related point. I may say that we are engaged at the present time, in Canada, with the problem of the mental condition of soldiers sent back as insane, and also with that of the mental condition of soldiers departing for the front. I would suggest to your Association the necessity of impressing upon your government the importance of adequately dealing from the very outset with the question of insanity in the army. We have made recommendation to the Dominion Government to establish regional psychiatric boards similar to those which were established in France early in the war, in order to supplement the work of the Army Medical Corps at the front. The work of these boards will, above all, enable the government to remove from the

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army the recruit who is mentally deficient and thus save the country from the danger, worry and expense that his presence in the ranks entails.

THE PRESIDENT.—The next paper will be read by Dr. Chas. P. Bancroft, of Concord, N. H., "Ought Limited Responsibility to be Recognized by the Courts?"

Dr. Bancroft's paper was discussed by Drs. Wm. A. White and Harris and Dr. Bancroft in closing.

The President then announced as the next paper, "Sketches from Psychiatric Clinics of Yesterday, To-day and To-morrow," by William McDonald, M. D., Providence, R. I.

There being no discussion of Dr. McDonald's paper, the President announced as the next paper, "The Need of Closer Relationship between Psychiatry and the Medical Schools," by Arthur H. Ruggles, M. D., Providence, R. I.

DR. RUGGLES.—Mr. President, Dr. James, in his address this morning, stated that he thought that a paper bearing on this subject should be presented. I am afraid if he were here he would be disappointed in one respect, at least; and that is, because it is rather elementary. I was not in a position to outline an ideal course in psychiatry that a medical school should give. I have only attempted to point the way in which more energetic work among teachers of psychiatry should go, and to make a plea for a more intensive scheme of clinical teaching before the student goes out to practice. I am sure that the simplicity of the terms I have used would appeal to Dr. James and I am also of opinion that the brevity of my paper will appeal to all of you.

At the close of Dr. Ruggles' paper it was discussed by Drs. Bancroft, Locke, Harris and Dr. Ruggles in closing.

The President announced as the next paper, "Psychiatric Problems at Large," by A. J. Rosanoff, M. D., of New York.

At the close of Dr. Rosanoff's paper, the President suggested that discussion be deferred until Dr. Walter B. Swift's paper, "Essential Phases of Psychology for Medical Schools," had been read.

Dr. Swift then read his paper, after which the papers of Drs. Rosanoff and Swift were discussed by Dr. Wm. A. White.

At the close of Dr. White's remarks, the Association took a recess until 8 p. m.

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Evening Session.

The President called the Association to order at 8.15 p. m.

The President.—The first paper scheduled for this evening to be read by Dr. Adolph Meyer will be deferred until the auditors have presented a report.

Dr. Heyman presented the following report:

May 29, 1917.

I hereby certify that I have examined the bills, vouchers and papers submitted by the American Journal of Insanity as to receipts and disbursements, and compared the accounts with the reports submitted to the Association and find the same correct as submitted.

W. B. Heyman, *Auditor.*

On motion the report of the auditor was accepted and adopted.

The President then announced as the title of Dr. Meyer's paper, "The Aims and Meaning of Psychiatric Diagnosis."

At the close of Dr. Meyer's paper the President announced that discussion was in order.

Dr. Meyer's paper was discussed by Dr. Abbot and Dr. Meyer in closing.

The President announced the next paper, "Preventable and Avoidable Causes of Insanity," by Dr. Charles W. Burr, of Philadelphia, Pa.

This paper was discussed by Drs. Wm. A. White, Southard, Mitchell, Adolf Meyer and Dr. Burr in closing.

The President announced that owing to Dr. Hoch's absence, his paper on "The Psychoses Associated with Cerebral Syphilis Resembling the Constitutional Reaction," would not be presented and that the next paper would be read by Dr. Earl D. Bond, of Philadelphia, "A Study of Self-Accusation."

At the close of Dr. Bond's paper, the President again reminded members and visitors of the necessity of registration.

There being no discussion of Dr. Bond's paper, the President announced the next paper as "Dementia Præcox in Early Childhood," by Dr. C. K. Clarke, of Toronto, Ontario.

Dr. Clarke not being present at the meeting, the President announced as the next paper, "Principles of Diagnosis in Psychiatry," by Dr. E. Stanley Abbott, of Waverley, Mass.

At the close of Dr. Abbot's paper, there being no discussion, the President announced the program of the evening session completed and the Association adjourned until Wednesday morning, May 30, at 10 a. m.

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Wednesday, May 30, 1917.

Morning Session.

The President called the Association to order at 10.05 a. m. and announced that Vice-President Anglin would preside during his temporary absence from the morning session.

The President called for a report of the council.

The Secretary announced that the following names were submitted for associate membership and that it would be necessary to have them lie on the table until to-morrow when action could properly be taken:

Karl Murdock Bowman, M. D., White Plains, N. Y.; Charles I. Lambert, M. D., White Plains, N. Y.; Wm. W. Eichelberger, M. D., Harrisburg, Pa.; Donald R. Gilfillan, M. D., Worcester, Mass.

The Council recommends for final action to-day the following:

Felix M. Adams, M. D., Vinita, Okla.; Charles R. Ball, M. D., St. Paul, Minn.; Edwin P. Bledsoe, M. D., Little Rock, Ark.; Robert Morris Butler, M. D., Jackson, Miss.; Charles Macfie Campbell, M. D., Baltimore, Md.; Lionel L. Cazenavette, M. D., New Orleans, La.; Marcel J. De Mahy, M. D., New Orleans, La.; John W. Duke, M. D., Guthrie, Okla.; Edward J. Engberg, M. D., St. Paul, Minn.; Charlotte S. Farrington, M. D., Philadelphia, Pa.; Henry G. Gahagan, M. D., Elgin, Ill.; James Greenwood, M. D., Houston, Tex.; Ernest M. Hammes, M. D., St. Paul, Minn.; Charles B. Hill, M. D., Supply, Okla.; Andrew W. Hoisholt, M. D., Napa, Cal.; Arthur G. Hyde, M. D., Cleveland, Ohio; H. C. Kehoe, M. D., Frankfort, Ky.; Cheston King, M. D., Atlanta, Ga.; William S. Lindsay, M. D., Topeka, Kans.; S. Metz Miller, M. D., Norristown, Pa.; Angus W. Morrison, M. D., Minneapolis, Minn.; Joseph A. O'Hara, M. D., New Orleans, La.; F. L. Peddicord, M. D., Lakeland, Ky.; Harriet E. Reeves, M. D., Melrose, Mass.; G. E. Scrutchfield, M. D., Farmington, Mo.; Charles V. Unsworthy, M. D., New Orleans, La.; A. F. Young, M. D., Milwaukee, Wis.; Beverly Young, M. D., San Antonio, Tex.

These names were presented a year ago after action by the Council, were read by the Association, were read again by the Council and presented again to the Association for final action.

Dr. Woodson.—Mr. President, as much care has been taken in going over the names of these applicants, I move that the Secretary be permitted to cast one vote representing the action of the Association on these several names at this time.

The motion was duly seconded and adopted unanimously and the President declared the applicants elected to active membership.

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The Secretary announced the following list of candidates for transfers from associate to active membership: These have all been members for three years or more and are eligible for such transfer as they request. They were read yesterday and are recommended by the Council for such transfer.

Paul J. Alspaugh, M. D., Massillon, Ohio; Earl D. Bond, M. D., Philadelphia, Pa.; Edgar L. Braunlin, M. D., Dayton, Ohio; George F. Brewster, M. D., New York, N. Y.; H. M. Brundage, M. D., Columbus, Ohio; Ross McC. Chapman, Washington, D. C.; E. H. Cohoon, M. D., Boston, Mass.; Arrah B. Evarts, M. D., Washington, D. C.; John B. McDonald, M. D., Hathorne, Mass.; A. C. Matthews, M. D., Napa, Cal.; H. C. Podall, M. D., Norristown, Pa.; Charles F. Read, M. D., Watertown, Ill.; Ralph S. Reed, M. D., Central Islip, N. Y.; Arthur H. Ruggles, M. D., Providence, R. I.; Wm. B. Terhune, M. D., Jackson, La.; Tom B. Throckmorton, M.D., Des Moines, Ia.; Adaline Westcott, M. D., Newburgh, N. Y.; Esther S. B. Woodward, M. D., White Plains, N. Y.

Dr. Smith.—Mr. President, I move that the transfer of names be authorized and the Secretary be directed to cast one ballot representing the Association in transferring these associate members to the active list.

The motion was duly seconded and adopted unanimously.

Dr. Brush.—Mr. President, I have prepared a preamble and resolution on the subject of the cooperation of this Association with the heads of the army and navy and the recruiting services which I would submit for your consideration.

Dr. Brush's resolution was as follows:

The American Medico-Psychological Association, composed of physicians in charge of or connected with institutions for the insane and mentally defective in the United States and Canada, or who in their practice devote themselves to psychiatry or neurology desires

First, to place on record its hearty accord with the government of the United States in its active participation in the European war.

Second, it desires to offer its services as an organization and the services of its individual members as far as such services can be effective or can be made available in doing everything possible to render the participation of the United States in the conflict more active, more certain and more efficient. To accomplish these purposes it believes that the services of trained psychiatrists and neurologists are necessary and should be availed of in at least three departments of the medical service of the United States Army and Navy, and that these departments are in the order of importance:

First, the recruiting service.

Second, the base of field hospitals at or near the scene of active military activities.

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Third, hospitals already established or to be established in the country for the reception of soldiers or sailors needing hospital care in this country or sent here from overseas.

Resolved, Therefore, that representations be made to the Surgeons General of the United States Army and Navy and to the staff corps of the army and navy urging the employment, as far as possible, in conjunction with the medical officers of the army and navy on recruiting service of psychiatrists and neurologists to aid in the examination of volunteers and of conscripts to the end that persons suffering from mental disorder or defect or with neuroses, and persons who appear obviously unfit for service by reasons of psychopathic tendencies be prevented from entering or being retained in either branch of the service.

Resolved, further, that to accomplish the objects of this Association there shall be appointed by the Chair a committee to be called the Committee on Military and Naval Organization, which shall be instructed to communicate with the proper authorities of the War and Navy Departments, with the Council of National Defense, the Research Council and with the National Committee for Mental Hygiene, urging the necessity of psychiatric and neurological cooperation and work in the three lines heretofore enumerated, and in such other directions as may upon conference be further determined.

Resolved, that this committee, after such consultation with the departments and organizations above enumerated, be instructed to formulate plans for the cooperation of this Association as a body, and of its members individually with the departments of the army and navy, which plan shall be submitted to the Council of this Association for approval.

Resolved, That upon the approval of the plan or plans the committee be authorized and directed to at once communicate with the individual members of this Association and prepare a list of such members as are willing:

First, to serve as psychiatric consultants for various military and naval branches either in recruiting service or the examination of recruits or sailors in training.

Second, to enter one of the reserve corps for such service in psychiatry as may be required.

Third, who would be willing to be assigned to duty during the war in this country for any medical service?

Fourth, who would be willing to perform needed duties overseas of any kind required?

Fifth, who would be willing to be attached to psychiatric units; first, at home, second, abroad, during the war?

Resolved, That the committee charged with the performance of the duties above enumerated shall confer with the committees from other medical organizations as far as may be possible or as may seem to the committee of value in order to prevent the duplication of work and to bring about complete and harmonious cooperation with other medical organizations having similar purposes in view.

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Resolved, That the committee be authorized to draw upon the Treasurer for actual expenses in an amount not to exceed ——, to be accounted for by proper vouchers.

The resolutions were seconded by Dr. MacDonald.

THE PRESIDENT.—I would like to say in this connection that I had prepared a resolution as referred to in my address, which I intended to offer; but Dr. Brush's resolutions are so much more comprehensive and cover so satisfactorily all that I had in mind that I shall not offer my resolution but ask your consideration of his.

DR. WOODSON.—Mr. President, although this committee appears to be willing to vote money from the treasury to carry out the purposes outlined, it occurs to me that a committee appointed by yourself on this occasion ought to be patriotic enough to work without compensation. Every one is doing something to help preparedness along and we have made a heavy draft on our treasury, and to make an appropriation for a blank sum to be used, I think that ought not to be favored by the Association. It will not be very difficult to get the United States Government to accept the services of any man who wants to enter the army, if he is competent, and to formulate and to write a few letters and to correspond with the proper authorities will not cost very much; it ought to require very little outlay, indeed.

I think with this exception Dr. Brush's resolutions are entirely suitable. I think the reference to the taking of funds from the treasury ought to be left off and I move that that part be stricken off.

DR. BRUSH.—Mr. President, I am afraid Dr. Woodson is unduly frightened by that word "blank" or by the word "money." I expected that the amount would be filled in and a definite sum fixed for expenditure when the resolutions were adopted, if they were adopted. I am quite sure that every man belonging to this organization who would be appointed by the Chair on this committee would be entirely willing to put his hand in his pocket and contribute to the expense of the work, but I think Dr. Woodson minimizes the amount of work to be done. I want to say to the Chair and to any gentlemen who may be appointed on this committee that it is a much larger work than Dr. Woodson apparently has any idea of. I conferred with the departments of the army and navy and I have conferred with members of the Council for National Defense concerning these matters. I pointed out last week three instances in one day, one of a high grade, dangerous imbecile enlisted in the navy who only last August made a homicidal attack upon a young man; another of a man suffering from a hypomaniacal condition who the day he was enlisted came under my care; and the third, with a paranoid dementia præcox was enlisted in the army and remained there long enough to be a potential pensioner upon the government. He ought never to have been received; in fact, none of them should have been received. I am willing to go to the recruiting stations near me whenever my services are asked for purposes of consultation

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with the authorities if they come across any case needing my attention, but they have no authority to ask any advice in consultation, or any assistance.

I feel that I have some ability in making a neurological or psychiatrical examination but the department gives me no authority and until I get that, what can I do. I am not the only one who has had these difficulties. I came here on Sunday with a gentleman who is now on the seas, giving up a very lucrative practice to perform special medical service abroad. He has been laboring with departments at Washington for months to get them to appreciate the necessity of employing specialists in various departments in the recruiting service alone to say nothing of the hospitals abroad and in this country. Now, if a plan is formulated, and I believe that a committee can be chosen from this Association to formulate a plan, it will be a feasible plan which can be brought to the attention of the authorities at Washington and so formulated as to enable each one of us to do our bit. If that plan is formulated I imagine it will involve the personal writing to every member of this Association to find out what hole he is willing to place himself in; what emergency he is willing to meet; how far he is willing to sacrifice his time and his energies in rendering aid to the government. It will require a good deal of work, the expenditure of a considerable amount for postage, a certain amount of travel—in fact, it is going to require a good deal of attention and the constant time of a stenographer or two for two or three weeks. If the Association treasury hasn't the money I am perfectly willing for one to do what the American Neurological Society did in Boston last week in assessing every member $10 to pay for work similar to this. Are we going to be behind them? Are we going to be afraid to spend some money when our friends on the other side are spending their blood? I believe not.

Dr. White.—Mr. President, I am heartily in favor of this Association placing itself upon record in any proper way in offering to furnish expert services in the various ways outlined by Dr. Brush; but it is going to be quite a job to do that and I think the Association should avail itself of all the various agencies which are now existing and inasmuch as there is one to which I belong engaged in the work already, I will venture to mention it. The National Committee for Mental Hygiene is already in the field and anything this Association does ought to be done, if not in conjunction, at least in cooperation with them, so that the two fields of endeavor do not cross. The National Committee has already a subcommittee appointed for furnishing psychiatric units to the army and navy. Their plans have been reviewed by the surgeon generals of the army and navy and we have already been requested to furnish the personnel of four psychiatric units for service abroad and I expect those units will sail in a few days. The National Committee has been recognized by the War and Navy Departments for this particular work in exactly the same way that the Red Cross has been recognized for getting together the Red Cross units; and the army and navy recognize this to such an extent that the

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National Committee is expected to recommend volunteers and these are accepted by the government. In this way something could be accomplished through cooperation with the National Committee. This committee is constantly working along this line, is in continuous session all the while, and if the committee of this organization is coming into the business they must be prepared to be at it also all the while. It is not simply the passing of a resolution; it means work and plenty of work. Then I am pleased to inform this Association that the matter of psychiatry has come to be represented upon the Research Council of Defense. Dr. Paton has been appointed on the Council and has appointed a Committee on Psychiatry; so there is a research committee on psychiatry, the function of which will undoubtedly be to take up all matters which bear even indirectly on these problems. We have the problem of enlistment; what kind of people are presenting themselves and what number should be rejected. I can assure the committee that there will be something more for them to do, other lines of activity than merely writing to the Defense Council, which is a proper enough thing to do. Now I have a suggestion to offer to Dr. Brush in regard to that blank in his resolution and in regard to the money. Let us begin now and deny ourselves some of our pleasures. Somebody went around and got a lot of money from various merchants totalling $975. I move that in the space left blank in Dr. Brush's resolution the sum of $975 be set aside for the use of this committee in their work. If we want to go on excursions let us pay our own expenses.

At this point Vice-President Anglin took the chair.

Dr. Meyer.—Mr. Chairman, I should like to say that I believe that the motion of Dr. Brush should be accepted for consideration by a committee which would take up immediately the consideration of collaboration with the forces already at work so that the energy of this Association can assert itself to the best possible advantage, and I should therefore like to motion that the Chairman appoint a committee which should take up to-day this problem of collaboration to report to-morrow some plan of procedure.

The motion of Dr. Meyer was seconded by Dr. S. E. Smith.

Dr. Brush.—Mr. President, I think that is a most excellent idea. I think you will recall that I said in the resolutions I introduced that we should confer with the National Committee for Mental Hygiene and with the Council of Defense but I may have left out inadvertently the Research Council; I should have added that, and also such other organizations and committees as are working for harmonious action and for the prevention of duplication. I believe any committee appointed should cooperate with the National Committee for Mental Hygiene. Dr. Meyer's idea is a most excellent one, to report to-morrow as to the best plans for cooperation, for certainly we must avoid the tremendous duplication of effort going on all over the country.

Dr. S. E. Smith.—Mr. President, before the motion is put, I would like to say that I am in full agreement with the resolution and will vote for it

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and I think that the reference to a special committee is very wise and proper and will serve to prevent duplication of work. I believe it is important for this Association to begin at the ground but not to cover the ground already covered by the National Committee for Mental Hygiene; I would vote against the motion if I didn't think that the good sense and judgment of the committee would lead them to cooperate with the National Committee. It is too late for us to start this work independently and build it up wholly within the Association.

DR. BRIGGS.—Mr. President, I would like to say that in Massachusetts we have got that investigation under way. We have a committee appointed to ascertain how many of our superintendents and our mental men desire to undertake active service and where they will serve. The papers are filled out by all of the medical officers of our state hospitals; we have 61 papers in all to date. It was the desire of this sub-committee in Massachusetts to do this work for our state and to place all their material in the hands of the National Committee for their consideration and for their information as to whom they might call on and for what service. I think that this committee can, in some such way, cooperate with the National Committee for Mental Hygiene so that all duplication would be avoided.

President Wagner resumed the chair.

DR. CARLOS MACDONALD.—Mr. President, with all due respect to Dr. White, who suggests that the funds in the hands of the Committee on Arrangements be turned over to meet the expenditures of this committee, I would say that as the obligations already incurred or contracted for will probably exhaust the fund, the Committee on Arrangements would not feel at liberty to turn it over to the Association to be used for other purposes. I am, however, perfectly willing to put my hand into my own pocket to any extent that may be necessary to meet my share of the expense of this movement, for I am heartily in favor of it.

The work that psychiatrists and neurologists are expected to do should not require an age limit or a consideration of it, providing a man is in good physical and mental health, and vigorous and active. We, as psychiatrists, are perfectly qualified to examine recruits with reference to their mental fitness for the service, and to pass upon applicants for discharge on the ground of nervous and mental disability. I, for one, feel perfectly qualified to perform that work either here or overseas.

DR. BLUMER.—Mr. President, before taking up the business I have in hand I should like to say for the encouragement of Dr. MacDonald and other older members of this Association who may be in the stage of euphoric presenility that Dr. W. W. Keen, of Philadelphia, who is 80 years of age, has recently received his commission as major, his first commission having borne date of 1864.

I have a report, Mr. President, from Dr. Hurd, of the Committee on the Institutional Care of the Insane. I will read his letter first.

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BALTIMORE, May 19, 1917.

DEAR DR. BLUMER: Enclosed please find my statement as Chairman of the Committee on the Institutional Care of the Insane, which I have just signed. You see where we stand and that I have asked for an appropriation to cover the deficit of the first three volumes with authority given to the Council to order the payment of the deficit on the fourth volume when that account is settled up. I anticipate that this will not be far from eight or nine hundred dollars, but I cannot decide the matter just now.

If you think it desirable to make any changes in the report please do so. I also send a copy of the report of the Johns Hopkins Press, which I think I had better file with this report.

I am sorry not to be able to go to New York. I really think I should be a nervous wreck if I spent a week there in attendance upon the Association.

With kind regards,

Very truly yours,
HENRY M. HURD.

The report of Dr. Hurd is as follows:

BALTIMORE, May 17, 1917.

To The American Medico-Psychological Association.

GENTLEMEN: As Chairman of the Committee on the preparation and publication of The Institutional Care of the Insane I present herewith in behalf of the Committee a report covering the first three volumes.

I regret to say that the estimate made as to the size and expense of the work was an erroneous one, due principally to two reasons: First, the increased number of illustrations which were finally inserted because of a desire to present as nearly as possible a full representation of the state institutions, together with portraits of men who had been instrumental in promoting the care of the insane during the past three-quarters of a century, and second, the greatly increased size of the volumes over what was originally planned. Undoubtedly the amount of material could have been cut down, but it seemed to the Committee unwise to do so, in view of the fact that the histories of institutions in the different states gave original documents and details which if not printed at the present time might disappear wholly. In fact, in the course of investigations which were made it was found that in many states such documents had been destroyed and no satisfactory account could be given of the development of their institutions.

For these reasons the four volumes will contain upwards of about 2700 pages and 166 illustrations. There are at present a little more than 400 subscribers to the set. The edition numbers 800 copies. There has been received from subscribers to the work $2948.67, and there is still due $187.25, making a total of $3135.92. The cost of publishing and distributing the first three volumes has been $5629.57, and there is a deficit to date on the first three volumes of $2664.53. I would ask the Association to make an appropriation of this amount to pay the indebtedness upon the first three volumes. Volume IV is now in the hands of the printers and will probably

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be issued sometime during the month of June. I would also ask that the Council be given authority to pay the deficit on this volume, which cannot yet be determined but which will probably not exceed eight or nine hundred dollars.

There is no doubt but that eventually every copy of the book will be sold and the receipts from it will become an asset to the Association. Unquestionably the war conditions have interfered with its sale to a certain extent, especially in Canada. I believe that no medical association in this country has made a more worthy publication than this history, or one which will be more serviceable to the profession, both now and in the future.

In closing I desire to express my sincere thanks for the patience which has been extended to the Committee in view of the slowness of the completion of the work. It has been an onerous task and has required a large amount of personal effort on the part of all who have been engaged in its preparation.

Very respectfully submitted on behalf of the Committee,

HENRY M. HURD,
Chairman.

I suppose this report will go, in its regular course, to the Council, but I should like to say especially with reference to Dr. Hurd's last sentence, "It has been an onerous task," etc., that while there is no disposition on my part to belittle the performances of Dr. Hurd's associates and subeditors, I can speak for myself, as a sort of scout-master for the New England states, and avow that the kind of work that I have done has been in quantity and quality almost negligible. But I think all of the co-editors will agree with me when I say that the work done by Dr. Hurd has been onerous, unremitting and herculean. Neither is it too much to say that the disability under which our dear friend now labors, namely, that of detachment of the retina, with complete blindness in one eye and exceedingly poor vision in the other, is due in large measure to the unceasing work which for many years he has performed for this Association and especially on this *magnum opus* of his. I would, therefore, suggest, Mr. President, that somebody other than myself make a motion that this Association direct the Secretary to send an appropriate telegram to Dr. Hurd, expressing its sincere regret, its affection, and its great sympathy with him in his present ill health and disability. I am sure that such a message would please Dr. Hurd very much. It would also please him, no doubt, to hear in that same telegram what disposition has been made of this report.

DR. S. E. SMITH.—Mr. President, in view of the suggestion of Dr. Blumer I wish to move that the Association direct the Secretary to send the telegram of sympathy and appreciation to Dr. Hurd and to assure him that the deficit referred to has been taken care of.

The motion of Dr. Smith was seconded by Dr. Brush, who said:

When I first called on Dr. Hurd, following his trouble with his vision, I found him worrying more apparently about the final proof of the third

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volume of the work, which he has so well edited, than about his impaired vision.

Needless to say that was taken care of, the proofs were read and the volume was put through the press. I may say that when the final proofs were read they showed the very great and painstaking care the doctor had given to that volume, as indeed he had given to the other two. There were practically no corrections to be made in the final proof. The preparation of these four volumes for the press has been a labor of love on his part but it has been a labor which I do not think anybody in this room can appreciate. I am very glad we are to give him assurances as to this matter by a telegram and I think also there should be a letter from the President of the Association, expressing appreciation of what Dr. Hurd has done for this organization. I think you will be glad to know that the doctor's right eye of which he has had practically no use for a long time for reading or writing permits him to get about with a fair degree of comfort. He did not want to come here to strange surroundings, in a strange hotel, but he goes down town in the street cars sometimes, gets about and attends society meetings and remains his old cheerful self, ready as always for any service he can perform.

The motion of Dr. Smith was then unanimously adopted.

DR. BLUMER.—Mr. President, may I have one more word on this matter of sending telegrams. I was informed on coming into this room this morning that Dr. John B. Chapin, of Canandaigua, has been a member of this Association for 50 years. It seems to me it would be an extremely gracious thing if the Secretary should also be requested to send our venerable member the congratulations of the Association. Dr. Chapin is the dean of our Association, the oldest member, although the second oldest, I imagine, in point of age since Dr. Smith leads him by several years.

The late Bishop Bloomfield once, late in life, visited the University Church of Cambridge and there recognized a verger whom he remembered as of his undergraduate days. The bishop said in his surprise that he was glad to see him looking so well at such an advanced age, whereupon the old man answered, "Oh, yes, my lord, I have heard every sermon that has been preached in this church for 50 years and, thank God, I am a Christian still."

I think we ought to let Dr. Chapin know that we are all grateful for the kind of Christianity he has displayed during his half-century of membership notwithstanding the temptations by which he must have been beset, like the verger of Cambridge, to depart from his standards of faith and conduct.

The motion of Dr. Blumer was seconded and adopted unanimously.

DR. C. B. BURR.—Mr. President, in order to carry into effect the suggestion of Dr. White, which appealed to me very strongly I would move

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that an assessment of $5.00 be made upon every member present and collected immediately for the purpose of entertainment at this meeting, in order that the money to which reference has been made can be diverted as Dr. White suggested to the payment of the expenses of the special committee to be appointed on Dr. Brush's motion.

DR. CARLOS MACDONALD.—Mr. President, I beg to say that the Committee on Arrangements does not feel authorized or warranted in diverting any of this money for the purpose suggested. The committee holds it must be applied to the purposes for which it was subscribed, especially as the contributors are not members of the Association.

THE PRESIDENT.—I would like to say that as President, I signed with Dr. Mabon, who was the original Chairman of the Committee of Arrangements an express stipulation—practically an agreement—with every subscriber to this fund as to the nature of the use to which the funds were to be put. The subscriptions were made for a definite purpose and Chairman MacDonald, who succeeded Dr. Mabon having incurred such obligations, must meet them out of these funds.

DR. BLUMER.—Mr. President, I would amend Dr. Burr's motion that the sum be $1.00 and that the total sum be filled in where the blank occurs in Dr. Brush's resolution.

DR. WOODSON.—Mr. President, do our rules permit us to make assessments or do we do it by vote?

DR. BRUSH.—Mr. President, would it not be better to lay the whole matter over until the committee called for by Dr. Meyer's resolution is appointed?

DR. BURR.—Mr. President, I withdraw my motion.

THE PRESIDENT.—A committee should be appointed at this time to report to-morrow on Dr. Brush's resolution. I would appoint, as such committee, Dr. Brush, Dr. Meyer, Dr. Blumer, Dr. Carlos F. MacDonald and Dr. Work.

DR. BRUSH.—Mr. President, will you be kind enough to name Dr. Meyer first as he is the one who will take up the matter which I have brought to the attention of the Association.

THE PRESIDENT.—I will be glad to make the change that you suggest.

DR. WORK.—Because of the very great distance at which I live from my associates on this committee, I would like to ask that another name be substituted for mine.

No action was taken on Dr. Work's suggestion.

DR. S. E. SMITH.—Mr. President, we have not taken care of the report read by Dr. Blumer or at least I don't recall that any action has been taken on it. If that is the case I move that it be referred to the Council.

The motion of Dr. Smith was duly seconded and adopted.

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THE PRESIDENT.—It appears to be proper under this order of business to have reports from some committees. In the first place a report that was made by Dr. Copp was laid on the table to be taken up this morning; that is, the report of the Committee on Statistics. I do not know that the Association is prepared to adopt the report but it was expected that after having 24 hours to think it over the Association could properly discuss it this morning and decide whether to take action now or defer it for a later session. I would, therefore, ask if there is anything further to be said or any action taken on the report submitted yesterday by Dr. Copp, entitled "The Statistical Report."

DR. COPP.—Mr. President, the committee has expressed itself in the report which you have before you, therefore no remarks from the committee are necessary at this time. It is possible that it would be proper to emphasize what the committee deems the essentials of the report which should be considered for immediate action, if any action is deemed advisable. The recommendation as to the classification of mental diseases and the uniform tables for statistical data should, we think, be adopted. Then it would be necessary to provide: first, for the promotion of the adoption of this classification by the different states; and, second, for its periodical revision by a standing committee.

This standing committee should represent the best psychiatric knowledge and be composed of the men doing the best, scientific, medical work in the institutions. It should be continuous in its study of the subject and by its recommendations from time to time present the most up-to-date statistical forms.

The recommendation that a statistical bureau be established at a considerable expense by the Association is not essential and, perhaps, not advisable at this time.

THE PRESIDENT.—Have you a definite suggestion that you would make?

DR. COPP.—We would like to have come up the question of adopting the tables as recommended or, if not adopted, such definite suggestions as will make them acceptable as a starting point.

DR. BRIGGS.—Mr. President, I would like to speak of the necessity for immediate action. As a member of the National Committee preparing neuropsychiatric units for the United States Government we are endeavoring to have a uniform set of records used in all these units. Dr. Salmon's desire was that blanks be immediately formulated and made uniform so that at the end of the war there would be one uniform set of records and a complete psychiatric history of the war such as there never had been after any other war. If a uniform classification and blanks for statistics could be adopted at this time it would be of extreme value at the end of the war in writing up the history.

DR. HUTCHINGS.—Mr. President, as I am neither a member of the committee nor a resident of any of the states represented on this committee at the present time, I feel that it would be appropriate for me to urge the

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adoption of this report. Personally I favor it very greatly. It has been prepared after full consideration and it is entirely practical and ought to be used throughout the institutions in this country and it has been suggested that it be used also in the psychiatric units now being formed under the auspices of the National Committee for Mental Hygiene. So I will move that the report as presented by Dr. Copp be adopted so far as the tables and classification are concerned.

DR. WOODSON.—Mr. President, I merely want to suggest that the attendance at the time the report was read was very small, and to express my opinion that a special time should be set for the consideration of this report so that the members may know what the tables consist of. I would suggest that the matter be deferred until some time to-morrow. If the Chairman will tell me what hour it will be convenient for the Association to consider it I will make a motion to defer it until that time.

DR. BRUSH.—The tables have been ready, they have been distributed and have been in the hands of every member of the Association for at least two weeks.

DR. WOODSON.—Mr. President, I have not seen them myself and I move that the subject be deferred until to-morrow.

DR. BURGESS.—Mr. President, allow me to say a word. I was late in entering. While the classification may be alright, to a practical man it is too complicated and neither I nor my assistants have time sufficient to fill these forms out if they are to be accurately filled. I think the same subject was gone over several years ago in the British Association and also in France, and they thought there that the general trend was to make such classifications too complicated. I read the one now suggested very carefully two or three times and I did not care for it much. In fact I'll be hanged if I could simmer it down to a common-sense basis.

DR. COPP.—We must bear in mind that no one in this classification can represent his individual opinion. The report itself does not represent the views of every individual on the committee, but it was an effort to present a practicable basis of classification. It will come before you, not as a compulsory but as a voluntary matter.

The whole matter is within your control. It is not a crystallized proposition. It is to be plastic, modified from time to time on recommendation of the standing committee. It is important that the United States Census Bureau, the Public Health Departments, state and national, and various associations should have some expression of opinion in this matter which is authoritative from this representative Association.

The President put Dr. Woodson's motion to defer consideration of the subject until Thursday afternoon. The motion was lost. The motion offered by Dr. Hutchings was adopted unanimously.

DR. BANCROFT.—Mr. President, in compliance with the suggestions of Dr. Copp with regard to the adoption of this report I understand that it is

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desired that there should be a constant committee, and if it is in order at this time to make that motion I should like to move that a standing committee on statistics, to be composed of seven members, be appointed by the President, to promote the general adoption of the Association's classification of mental diseases and statistical tables and from time to time to recommend to the Association such revisions as may be necessary.

Dr. Bancroft's motion was seconded and adopted unanimously.

THE PRESIDENT.—I take it that the incoming President will appoint that committee.

The next order of business will be the presentation of the report of the Committee on Diversional Occupation, Dr. Hutchings, Chairman.

DR. HUTCHINGS.—Mr. President, if it is agreeable, I would like to defer the reading of the report of this committee until to-morrow, as the exhibits are now being judged and I will be in a better position to report to-morrow morning.

The President then called for the report of the Committee on Pathological Investigation, Dr. E. E. Southard, Chairman.

DR. SOUTHARD.—Mr. President, let me speak of one matter before the report is presented. I hope that the Committee on Resolutions may deem it desirable to request the Association at a future meeting to adopt one or all of these resolutions—if they are proper for adoption.

To the American Medico-Psychological Association:

As Chairman of the Committee on Pathological Investigation, I wish to submit the following report:

This standing committee is composed of the following members: E. E. Southard, M. D., Boston, Mass., Chairman; Adolf Meyer, M. D., Baltimore, Md.; August Hoch, M. D., New York, N. Y.

The work of the Committee on Pathological Investigation has been interrupted by travel and illness of members to an unforeseen extent, and for the rest, preparedness questions relative to the war have put the matter of pathological investigation, as such, rather upon one side. However, all members of the committee have been engaged in various official and unofficial ways in work indirectly related to the work of the Committee on Pathological Investigation.

In the absence of a set report, the Chairman wishes to offer the following suggestions, which he believes conform to the ideas of the other members of the Committee with whom he has conversed from time to time on this topic, and the Chairman of the committee will offer as motions for possible adoption by the Association the following:

1. The Standing Committee of the Association on Pathological Investigation shall be empowered to appoint sub-committees from members of the Association relative to various aspects of investigatior

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2. To the above end the committee shall be directed to communicate with a portion of all of the Association to secure voluntary suggestions for topics and membership of such sub-committees.

3. That it is the opinion of the Association that pathological investigation and research in both structural and functional lines shall be encouraged in the institutions.

4. That to this end it be regarded as the opinion of the Association that pathological laboratories equipped for routine hygienic work in the institutions for the performance of autopsies and for clinicopathology form an indispensable portion of the equipment of large district hospitals for the insane.

5. And that it be regarded as the opinion of the Association that where such laboratory facilities are not available, within the walls of the institution, they shall be sought from nearby hospitals, medical schools or other institutions possessing such facilities.

6. That it be regarded as the opinion of the Association that in the absence of unusual circumstances, large district hospitals, such as those having 1500 beds or more, shall employ pathologists relieved from routine duties in connection with clinical work.

7. That the Association views with approval the connection of officers of state institutions with educational institutions, particularly those training medical students.

Respectfully submitted,
E. E. SOUTHARD. *Chairman.*

Dr. Southard also presented the report of the Committee on Scientific Exhibits, as follows:

To the American Medico-Psychological Association:

As Chairman of the Committee on Scientific Exhibit, I wish to make the following report:

The members of this standing committee are as follows: E. E. Southard, M. D., Boston, Mass., Chairman; Arthur W. Hurd, M. D., Buffalo, N. Y.; Albert M. Barrett, M. D., Ann Arbor, Mich.; Adolf Meyer, M. D., Baltimore, Md.; H. Douglas Singer, M. D., Kankakee, Ill.; H. W. Mitchell, M. D., Warren, Pa.

The engrossing interests of the majority of the members of the committee in connection with preparedness for larger matters have permitted only modest beginnings in the matter of a scientific exhibit. Exhibits have been sent from the New York Psychiatric Institute; the Psychopathic Hospital, Boston; the Massachusetts Commission on Mental Diseases; the Psychopathic Institute, Kankakee, Ill.; the Massachusetts School for the Feeble-Minded, Waverley; the Monson State Hospital, Mass.; the Trenton State Hospital, New Jersey; the Life Extension Institute (courtesy of Professor Irving Fisher); and the Eugenics Record Office, Cold Spring Harbor, N. Y. (courtesy of Director C. B. Davenport).

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The Chairman of the committee feels that the committee has learned the difficulties of its task, at least to some extent. Next year and in future years the committee hopes to extend and develop the exhibits so that all aspects of scientific work, whether fundamental and theoretical or related to the practical matters of diagnosis and treatment, will be properly represented.

Respectfully submitted for the committee,
E. E. SOUTHARD, *Chairman.*

The President announced that the reports would be referred to the Committee on Resolutions.

The report submitted by Dr. Southard as Chairman of the Committee on Pathological Investigation was then adopted.

The President announced as the next report that of the Committee on Mental Hygiene, Dr. William A. White, Chairman.

DR. WHITE.—Mr. Chairman, this is rather a lengthy report and consists of details of the various activities in mental hygiene through the past year throughout the country. I suggest that as it will be printed in our transactions, I would be glad to be relieved of the duty of reading it unless you insist; and that it be read by title.

The President announced that the request of Dr. White would be granted.

REPORT OF COMMITTEE ON MENTAL HYGIENE.

General Scope and Activities.—Although the specific objects of mental hygiene are to prevent mental diseases and mental defect and to promote mental health, the term is being applied in this country to a wide range of activities having to do with the care and management of mental diseases and mental deficiency and to the application of psychiatrical and psychological knowledge to many social, industrial and economic problems. This means that mental medicine is attempting to formulate a program for prophylactic activities.

Increased Interest in Mental Hygiene.—Recognition of the part of the federal government in work in mental hygiene led to the introduction of a bill establishing a Division of Mental Hygiene, under an assistant surgeon general, in the United States Public Health Service. This bill (S. 2215; H. R. 721) was passed by the House of Representatives and reported favorably by the Senate Committee on Public Health and National Quarantine. Sections on mental hygiene have been formed in the National Conference of Charities and Corrections and the American Medico-Psychological Association. A session of the 1916 meeting of the American Public Health Association was devoted to mental hygiene. A quarterly magazine entitled *Mental Hygiene* has been projected by the National Committee for Mental Hygiene. The first number was published in January, 1917. The extension of interest in this new division of preventive medicine has already created a demand for

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instruction in the subject and several universities are offering courses for those who desire to work in this field. It is planned to include a mental hygiene division in the Institute of Hygiene to be established at The Johns Hopkins University.

Work of Organizations.—The National Committee for Mental Hygiene has widened the scope of its work and with increased resources. New state societies have been formed in Indiana, Missouri, Ohio, Rhode Island and Tennessee. The second Convention of Societies for Mental Hygiene, held in New Orleans in April, was attended by representatives of ten of the thirteen societies established up to that time.

The Committee on Provision for the Feeble-Minded has devoted itself chiefly to popular education on a wide scale and to securing the appointment of official state commissions to study feeble-mindedness in its various relations and to recommend to their legislatures specific measures for dealing with this great problem.

Provisions for Treatment of Mental Diseases.—State surveys of the care and treatment of mental diseases have been carried on by the National Committee for Mental Hygiene during the year in California, Colorado, Connecticut, Georgia and Louisiana. The facilities for dealing with mental diseases are also being carefully studied in Chicago and New York City. These surveys which are undertaken at the request of governors, state boards of charities or of unofficial organizations enabled the committee to make recommendations of the greatest value. Although conditions of unbelievable neglect have been found in certain places, every effort is made to emphasize the constructive features of such surveys. An important phase of the treatment of mental diseases is the extension of the work of hospitals for the insane in the communities which they serve. By means of out-patient departments, or mental clinics as they are called, social service, after-care and popular education in the districts from which such hospitals receive patients, they are becoming in many states centers for practical and effective work in mental hygiene. At these mental clinics any case presenting a mental problem, whether in diagnosis, treatment or social management, receives the careful attention of qualified specialists.

An addition to the few centers existing for research into the causes and nature of mental diseases has been made possible during the year by the appropriation of $20,000 annually by the Sprague Foundation for the study of dementia præcox, an unrecoverable type of mental disease from which more than 60 per cent of the patients in public institutions for the insane are suffering. It is believed that there is no larger group of persons in this country afflicted with a single form of serious disease.

A number of important changes have been made in laws dealing with mental disorders. For the most part, the new legislation shows a tendency to aid in completing the hospitalization of institutions for the insane and to provide simpler and less formal methods of commitment. Voluntary admissions have increased so greatly since this means of securing treatment was first provided, that, in several institutions it is the method most frequently employed. There are strong grounds for believing that, before long,

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any other means of securing treatment will be the exception instead of the rule. The growth in the extent and cost of institutional care of mental diseases has led to a critical examination of methods of general control and administration. A significant change is the substitution of a State Board of Mental Diseases in Massachusetts for the State Board of Insanity. The tendency toward the formation of central boards of control has been checked by the disclosure of some evils which seem to accompany this system of administration.

The immigration bill, which passed the House of Representatives in 1915 and the Senate in December, 1916, contains provisions for the mental examination of all arriving immigrants by medical officers especially trained in psychiatry and requires that such officers shall have proper facilities for their work. It also adds to the excludable classes of aliens persons with several types of abnormal mental conditions not previously specified in the law.

The Bureau of Social Hygiene has established a psychopathic hospital in connection with the Reformatory for Women at Bedford, New York. While this was the only addition made to the number of psychopathic hospitals during the year, active efforts to secure such facilities are under way in New York City, San Francisco, Detroit, New Orleans, Galveston, Nashville and in connection with the University of Iowa.

There have been no notable advances in the treatment of mental diseases during the year except in dealing with general paresis, a very prevalent and uniformly fatal disorder. Stimulated by the discovery by Noguchi and Moore of the living organisms of syphilis in the brains of paretics, efforts have been made to combat this disease by the intraspinal and intracranial introduction of salvarsanized serum. Although it seems possible by this means materially to alter the progress of the disease, there is yet insufficient proof that cures or permanent arrests can be secured. Occupation and re-education have received especial attention in other forms of mental disease. It is becoming the general belief that mental diseases may be prevented or greatly modified by early treatment and so the detection and special management of psychopathic conditions in children is receiving a great amount of attention and facilities for carrying on this work in connection with the schools are being very strongly advocated.

Provisions for Mental Deficiency.—The great increase in popular interest in feeble-mindedness has continued. The state commissions appointed in Arkansas, Florida and Indiana have continued their work. New commissions have been appointed in Delaware, Kentucky and Utah. While institutional provision for the feeble-minded is still very inadequate, according to a census made by the National Committee for Mental Hygiene in June, 1916, there were 34,186 inmates in public institutions for the feeble-minded and epileptic in this country, an increase of 44.4 per cent since 1910. No other group of persons for whom institutional care is provided in the United States has increased at so rapid a rate, but even with the remarkable extension of interest in mental deficiency during recent years the percentage of increase from 1910 to 1916 is less than in the period 1904-1910. There

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has been general approval of the formation of colonies for adult male feeble-minded persons in good physical condition. Such colonies, when connected with "parent" institutions, can be made self-supporting and seem to offer a most hopeful means of providing for a greatly increased number of cases at a minimum expense to the state. The kind of provision most suitable for defective delinquents of both sexes has received much study but no state has yet made provision for this class.

A bill to provide an institution for the mentally defective in the District of Columbia resulted from the findings of the survey made by the United States Children's Bureau in 1915, but failed of passage. As existing legislation has been found inadequate to carry on much of the work planned on behalf of the feeble-minded, attempts are being made in various states to frame suitable laws for the commitment, registration, supervision, guardianship and institutional care of defectives. A comprehensive law was enacted in Virginia as a result of the report made by the Virginia Commission in 1915.

The educational authorities are awakening to their responsibilities for the care of mentally defective school children. Special classes for such children are being formed throughout the country. The demand for trained teachers in these classes has led to the establishment of special courses of instruction in a number of colleges and normal schools.

Surveys of Mental Deficiency.—During the year an important survey was completed in Nassau County, New York, to determine the social significance and the approximate prevalence of mental deficiency in a restricted area. In this survey, which was carried on by the National Committee for Mental Hygiene under a special appropriation by the Rockefeller Foundation, a careful estimate was made of the mental condition of all individuals in three areas selected for intensive study. In these areas, the population of which is about 5000, approximately 3 per cent of the total number were found to be afflicted at the time or to have suffered previously with some form of mental disorder including psychoses (insanity), all types of mental deficiency, epilepsy, constitutional psychopathic states and inebriety. About 4000 other persons in the county were studied, these being selected from the groups in which abnormal mental conditions seemed most likely to be found. The mass of data bearing upon the relation of abnormal mental states to delinquency, dependency and educational problems collected in this survey is without parallel and will be of the greatest value in formulating plans for dealing with mental deficiency. The United States Public Health Service has continued its very important school hygiene surveys in Arkansas, Delaware, Indiana and Maryland, and has taken an active part in the survey in Nassau County. The mental examinations in such surveys are made by medical officers with special training in psychiatry and they provide trustworthy data as to the prevalence of abnormal mental conditions in the community.

Mental Factors in Crime and Delinquency.—An unusual amount of attention has been paid during the year to the relation of mental factors in

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crime and delinquency. The pioneer work done by the Juvenile Psychopathic Institute in Chicago has resulted in the establishment of clinics in connection with children's courts in a number of cities.

The National Committee for Mental Hygiene, through a special appropriation by the Rockefeller Foundation, established a psychiatric clinic at Sing Sing Prison on August 1, 1916. The establishment of this clinic constitutes a part of the general plan for the conversion of Sing Sing into a reception prison where each prisoner received will be given a most careful mental and physical study. The clinic has proved not only a valuable means of studying the psychopathology of crime but has shown that the results of such studies can be applied very usefully to the conduct of prison affairs. Efforts are being made to establish clinics with similar aims in Connecticut, Massachusetts and New Jersey. Other evidences of the desire to study crime and criminals from a psychiatrical viewpoint are the appointment of a resident psychiatrist in the penitentiary and work-house at Blackwell's Island, New York City, the reorganization of the Police Psychopathic Laboratory in New York City with four psychiatrists, one psychologist and two social workers devoting their whole time to the task of studying the mental condition of persons arrested in that city, and the opening of a psychopathic hospital in connection with the Reformatory for Women at Bedford, New York, for the study and treatment of a selected group of psychopathic cases among women delinquents.

Inebriety.—The mental factors in inebriety are now receiving much more general recognition than heretofore. Effective cooperation between those engaged in the study of the inebriate, the insane and the feeble-minded promises valuable additions to our knowledge of the underlying causes of inebriety and its more successful management. The growth of heroin addiction among young persons is arousing much concern as it represents a new and dangerous form of drug inebriety. A step toward the control of this phase has been taken in the elimination of this drug from the medical supply tables of the United States Army, Navy and Marine Hospital Service and the introduction in Congress of a bill to prohibit entirely its manufacture, importation or sale. The very slight therapeutic value of heroin makes such a step possible.

Military Hygiene.—Perhaps the most important of the recent activities of the National Committee for Mental Hygiene has been the appointment of a Committee for Furnishing Hospital Units for Nervous and Mental Disorders to the United States Government. This committee has presented a plan for the building, organization and equipment of a psychiatric unit to be attached to the army and navy base hospitals, and both branches of the military establishment have recognized the virtues of this plan so far as to practically hand over the work of organizing these units to the National Committee, with a tacit understanding that the personnel recommended for manning these several units will be accepted. The committee undertakes to secure the funds for paying for the equipment of these units, which will be of two varieties as to size, the larger size accommodating from 115 to 150 beds and the smaller size approximately for 30 beds. The equipment of

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the larger unit will cost in the neighborhood of $10,000 and for the smaller unit approximately half that sum. At the present writing arrangements have been completed for establishing and equipping the first unit in connection with the Marine Hospital at Staten Island, which will be manned by medical officer of the Public Health Service who have had special psychiatric training. A plan is being formulated for handling mental and nervous cases, particularly for their disposal from the base hospitals. In order that as full and complete knowledge as possible might be obtained as to the methods that were of value and as to the new conditions which might be met in the realm of neurology and psychiatry and which would require methods of treatment with which we were not familiar, the National Committee has undertaken to send Dr. Salmon to France and England to make a rapid, intensive survey of the situation.

Other Problems.—It is apparent from the activities which have been described that mental factors are receiving an entirely new degree of attention in problems other than those which have previously constituted the special sphere of psychiatry and psychology. Tentative efforts have been made to find practical means of bringing the resources of these sciences to bear upon the problems of education, vocational guidance and certain phases of industrial work. Great impetus has been given these efforts by the new knowledge regarding mental mechanisms which recent advances in the methods of psychological analysis have provided.

It can be said conservatively that the progress in mental hygiene during the year justifies the belief that a more fundamental approach to social problems has been found than any which has heretofore existed.

Respectfully submitted,
WM. A. WHITE, *Chairman,*
WM. L. RUSSELL,
THOS. W. SALMON.

The President announced as the next order the report of the Committee on Revision of Propositions, Dr. Owen Copp, Chairman.

Dr. Copp suggested that his report be deferred until Thursday morning.

The President announced as the next order report of the Committee on Nominations, of which Dr. Carlos F. MacDonald is President.

DR. MACDONALD.—Mr. President and Gentlemen, the Nominating Committee would respectfully report the following nominations:

For President, Dr. James V. Anglin, of St. Johns, New Brunswick.

For Vice-President, Dr. E. E. Southard, of Boston, Mass.

For Secretary-Treasurer, Dr. Henry C. Eyman, of Massillon, Ohio.

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For Members of the Council for three years, Dr. Charles G. Wagner, of Binghamton, N. Y.; Dr. W. H. Hancker, of Farnhurst, Del.; Dr. Herman Ostrander, of Kalamazoo, Mich.; Dr. Sanger Brown, of Kenilworth, Ill.

Auditor for two years, Dr. Robert L. Richards, of California, to succeed Dr. G. H. Moody, deceased.

Auditor for three years, Dr. Wm. L. Russell, of White Plains, N. Y.

(Signed) CARLOS F. MACDONALD,
H. W. MITCHELL,
EDWARD N. BRUSH,
Nominating Committee.

DR. WORK.—Mr. President, we have received the report of the Nominating Committee and I move that the Secretary be instructed to cast one ballot for the Association for the men named for the respective offices for the coming year.

The motion was duly seconded.

DR. WOODSON.—Mr. Chairman, why not adopt the report first?

DR. WORK.—I will change the motion to read to adopt the report first and then desire to have the motion to include the recommendation that the Secretary cast one ballot in favor of the election of the members nominated for the respective offices.

The report of the committee was then adopted and the respective nominees were declared elected.

The President called for the report of the auditors on the accounts of the Treasurer.

Dr. Heyman reported from the Auditing Committee as follows:

NEW YORK, May 29, 1917.

I hereby certify that I have examined the books and vouchers submitted by the Secretary and Treasurer and compared the accounts with his report submitted to the Association and find that the same is correct, as submitted.

M. B. HEYMAN, *Auditor.*

The President announced that he had selected as members of the Committee on Resolutions, Drs. Work, Hill, of Maryland; and May, of Massachusetts.

DR. MACDONALD.—Mr. President, before you proceed to the literary program may I renew the announcement in regard to the excursion this afternoon. The Manhattan State Hospital boat, the *Wanderer,* will leave the pier at the 34th Street dock at 1.30 p. m. Luncheon will be served at once so that members will not need to look after this feature; and we expect to return to the hotel at 5 o'clock.

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The President announced that the first paper to be read was by Dr. William A. White, "The Problems of the Individual Patient in Large Hospitals."

There was no discussion of this paper.

Dr. E. E. Southard then read his paper entitled, "Further Work on the Anatomy of Feeble-Mindedness, and Especially Brain and Gland Studies."

There being no discussion of Dr. Southard's paper, the President announced as the next paper, "Does the Paretic Gold-Sol Curve in Psychiatric Cases Always Indicate Syphilis of the Nervous System?" This paper was illustrated by charts. At the close of Dr. Weston's paper the President announced that in order to reach the boat landing in time to start the excursion on steamship *Wanderer,* the remaining papers on the program would be postponed. He, therefore, declared the session at an end and announced that the evening session would be devoted as usual to the annual address.

A very large number of the delegates and their families as well as visiting strangers enjoyed the boat ride on the *Wanderer,* the route being down the East River to New York Bay and up the North River to Grant's Tomb and return.

Evening Session.

The President called the Association to order at 8.30 p. m. In announcing that the annual address would be delivered by Professor Edwin Grant Conklin, of Princeton University, the President said:

Ladies and Gentlemen: During many of the years of the life of this Association, it has been a custom to set aside Wednesday evening as the occasion for a notable feature. That feature has regularly been an address by some distinguished personage, usually a professional man of high standing, and sometimes in the medical profession and at other times in other branches of learning.

A year ago at New Orleans we listened to an exceedingly fine address by Professor Pierce Butler, Professor of English Literature in the Tulane University on "The Mad-Folk of Shakespeare's Time," and that address was greatly enjoyed by all who heard it.

Two years ago Professor Douglas Freeman, of Richmand, Va., delivered an address at Old Point Comfort on "Publicity and the Public Mind," and every one who was there will remember what a splendid address we had the

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pleasure of hearing. Three years ago at Baltimore, Professor Lewellys F. Barker, of The Johns Hopkins University, addressed us on "Internal Medicine," and that splendid address was a milestone in our history. I might go further back and mention other notable addresses all of which have been of an exceedingly high character and by all of which we have been greatly honored in having them presented before our Association.

This evening we are promised an address which I have every reason to believe will rank with the best that we have heard heretofore, and which, if I mistake, not, will establish a new level, a higher plane, than any that have preceded it. I have great pleasure in introducing Professor Edwin Grant Conklin, Professor of Biology in Princeton University, who will address us on "The Development of the Personality."

At the close of Professor Conklin's address, Dr. Brush said:

Mr. President, the close attention which this most eloquent address has received and the applause with which it has been greeted makes it a work of supererogation on my part to rise and propose for the speaker a vote of thanks from this audience. It has been my privilege to listen to many addresses; it has also been my privilege to hear many interesting topics treated by prophets. To you, sir, I wish to accord the crown, the title of true prophet, for you prophesied, Mr. President, that the interesting and notable addresses which had been delivered on previous occasions would be surpassed by the one we were to hear to-night. It is, of course, not proper for me at this time to draw invidious comparisons between addresses delivered before this Association. It is particularly so in view of the discussions that have occurred during some of our recent sessions. I wish that the gentleman who has spoken to us to-night could have taken part in, or at least been present at, the discussion which occurred over the paper by Dr. Burr. He has set before us an example; he has lighted a torch, he has sounded a warning and he has given us a motto. He has told us to remember that an all-wise Providence is a much wiser and safer power to trust in than any propaganda. I propose, therefore, Mr. President, that the thanks of this body be given to the gentleman who has so eloquently addressed us and I suggest that you call for a rising vote.

THE PRESIDENT.—I would like to say that the prediction I made was no casual phrase coined for the occasion. It grew out of the fact that I had heard a great deal about Professor Conklin before he came here and I believed that the address would be up to the standard which Dr. Brush has so fittingly characterized and for which I am sure you will all be glad to rise as an expression of your appreciation and your thanks.

The Association then adjourned.

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THURSDAY, MAY 31, 1917.

MORNING SESSION.

The President announced the receipt of a telegram from Dr. Henry M. Hurd expressing his appreciation and gratitude for the action that was taken by the Association during the Wednesday's session.

The Secretary then read a report of the Council Meeting held May 31, 1917.

REPORT OF THE COUNCIL, MAY 31, 1917.

The Council voted to recommend to the Association that the Treasurer be authorized to extend to Professor Edwin Grant Conklin an honorarium of $50 to cover his expenses in attending the meeting of the Association at which he delivered the annual address on May 30.

The Council has fixed tentatively the City of Chicago as the place of the next meeting of the Association subject to the approval of the Association; it being agreed that the Council may change to some other point if conditions should arise during the course of the year justifying such action.

The Council recommends that the annual dues of members of the Association for the coming year be fixed at the same rates as last year, viz. $5.00 for active members, $2.00 for associate members.

By the Council,
H. C. EYMAN, *Secretary.*

THE PRESIDENT.—I may say in regard to the meeting in Chicago that the feeling of the Council was that the selection should be tentative. Conditions may arise that may require change of place before next year.

On motion duly seconded, the report of the Council was accepted and adopted.

THE PRESIDENT.—We had presented to the Association yesterday morning four applications for associate membership. These names are now before you for election:

Karl Murdock Bowman, M. D., White Plains, N. Y.; Charles I. Lambert, M. D., White Plains, N. Y.; Wm. W. Eichelberger, M. D., Harrisburg, Pa.; Donald R. Gilfillan, M. D., Worcester, Mass.

DR. WOODSON.—Mr. President, I move that the Secretary be authorized to cast one affirmative vote to represent the Association upon these applications for associate membership.

Dr. Woodson's motion was seconded and adopted unanimously.

THE PRESIDENT.—We have two or three matters in the way of committee reports to consider but before we proceed to them I will ask Dr. Pearce Bailey, Chairman of the War Committee of the National Committee for Mental Hygiene, to advise us in regard to certain matters which he has in mind.

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DR. BAILEY.—Mr. President and Gentlemen: Although I am not a member of this Association, I appreciate very much the opportunity of appearing here to-day to tell you what our committee has done in this present war emergency.

Sometime ago, last March, two or three of us went down to see General Gorgas, surgeon general of the army, and talked over with him the general question of the care of the nervous and insane which would come up in the event of war. He seemed interested in the proposition and asked us to look over the border camps on the Rio Grande. As the result of that trip we came back with recommendations to General Gorgas to assemble some means of caring for nervous and mental cases in the base hospitals of the army. He accepted that proposition and then we reported back to the National Committee for Mental Hygiene and Dr. Barker, the president of our committee, appointed a special committee "On Furnishing Hospital Units for Nervous and Mental Disorders to the United States Government." He appointed on that committee a number of men— as many as he could without making it too bulky—alienists and neurologists from the different parts of the country. We are now engaged in getting commissioned the medical personnel and enlisting the nurses, attendants and stenographers. The authorization we have from Washington, from the surgeons general of the army and navy is, I think, a fine one, and I think they are prepared to be advised in all matters concerning the two services and also to accept the nominations we make for these special classes of men. They have, of course, alienists and neurologists in both services but those men are occupied in active duties and I don't think that the surgeons general of the army or of the navy are inclined to assign them to this special work.

What we have done so far is to perfect the organization of the committee. In the first place, we have gotten reports as to the conditions in Canada, and the conditions in Canada are very similar to those in this country. Canada was called upon to increase its army from 4000 to 400,000 soldiers and they were also called upon to send a large block of their army abroad, which is the same situation, apparently, we are in. Canada had a certain advantage there because they had England to use as a base and all Canadians stopped there both on the way over and on the return home. The examinations leading up to the discharge of soldiers are also done there. In that respect, Canada is in a better situation than we would be in so far as this feature is concerned. The surgeon general of the navy has accepted a special pyschiatric hospital which this committee is now building on Staten Island. This hospital will be personally administered by the Public Health Service, but the equipment is to be made by this committee. Dr. Salmon, who is the medical director of the National Committee for Mental Hygiene, is now in Europe studying all the lessons that are to be learned there in order that our organizations here may be made adequate.

The surgeon general of the army has called on us for thirty bed units for Europe. They are ready to go as far as plans can be effected; they will

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go in conjunction with the base hospitals. I saw Surgeon General Braisted in Washington on Tuesday and he asked me then to undertake work which I think is of paramount importance. A splendid opportunity is offered at the Naval Training Station for the examination of recruits especially with regard to their temperamental qualities. The training stations receive 5000 new recruits a month. The men remain at the station for a month on probation and during that month can be found ineligible and discharged and the country can thus be relieved from any danger of liability for pension claims. The surgeon general has appointed a psychiatrist to Newport and one is now needed at Norfolk, one at Chicago and one at San Francisco. This committee would like to have the names of men for that service. It is a wonderful opportunity to demonstrate what psychiatry can do in picking out men suitable for military service.

For the purpose of—efficiency is getting to be a too much used word—but it seems to be quite important that this official war committee be recognized as the one which should communicate with the army and navy in regard to their needs and which should send the application for commissions to Washington. I think a great deal of the time of this committee could be utilized for that purpose. What the needs are, I don't think anyone is in a position to say, but the general idea at Washington is that they are preparing an enormous army for a war of two or three years duration and they seem to have in mind sending large forces—a million men—to Europe just as fast as they can get them there; and the government has also firmly made up its mind, I think, to send psychiatric units in connection with practically every base hospital. They will need a number of psychiatrists and neurologists in the army and navy in excess of anything that any one even considered at the outbreak of the war. In addition to the units which go abroad units will have to be placed in the concentration camps throughout the country and later, special psychiatric centers will be necessary in the care of returned soldiers. It is expected that probably 10 per cent of the forces in Europe will be returned as invalided soldiers and a very large proportion of these will have nervous affections of some kind requiring special care and attention. So the job that is ahead of us is enormous. Just what this committee does is as follows:

It gives information very promptly to men who wish to enter the service as medical officers as to how they will proceed to get their commissions. It arranges for their selected service; any one who goes in independently, even though he has a preference for neurological or psychiatric work, will probably have no opportunity to exercise it unless he gets on a special roster right away, and this committee will have charge of that official roster; so that men who send their names to us will have some assurance that they can go on with special work. The committee will probably be able to cooperate also with men who wish to decide as to foreign or domestic service. Many wish because of family, or age, or of financial condition, to serve in this country and this committee will sort those out; and those wishing to go abroad can go, as I hope there will be ample quantity for both home and foreign service. The same is true for state services.

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Dr. Briggs, I believe, has a statement that he will read as to what Massachusetts has done toward organizing these psychiatric units in that state, and that same arrangement can be made for any state. A still more difficult proposition to arrange and one that I think we have now found a solution for is to get enlisted men assigned to this work. That must be arranged with the military officers of each department, but I think we can get the services of enlisted men who have had special experience in the care of nervous and mental cases.

We have standardized equipment for units and this will include hydrotherapeutic and electro therapeutic and diagnostic equipment. We are now working on the standardization of history plans so that the neurological and psychiatrical services will come out of this war with data which will be invaluable for medical purposes in the future. This equipment varies, depending upon whether it is for foreign or domestic service. It is not possible to carry to Europe the elaborate hydrotherapeutic apparatus or the extra cabinets which we have put into units in this country. Some things are impossible. It is not possible now to guarantee what rank a man will have although I think due attention will be paid to his age and his qualifications and to his standing. But I don't think that anyone can now guarantee any man a special rank nor can anyone guarantee any assignment to any particular local post.

The committee is very much in need of the names of men who wish to be officers and the names of attendants who wish to go into the enlisted reserve corps. We have worked very hard at this matter for two months and the number whose papers are now filed is not very large. We need an enormous list of reserve men who can be called on in an emergency, and I hope that every one who is interested in this subject of neurology and psychiatry and especially you, members of this Association, will give us all the names of men who can serve in this capacity. (Applause.)

THE PRESIDENT.—Although our time is rather limited, Dr. Frankwood Williams, of New York, who is the acting medical director of the National Committee for Mental Hygiene will say a few words to us on this subject.

DR. WILLIAMS.—*Mr. President and Gentlemen:* Shortly after the conscription law was passed the attention of the committee was drawn to the fact that conscription would prove a serious matter in the state hospitals for the insane. We telegraphed the superintendents of the Massachusetts and New York state hospitals and found that from 27 to 75 per cent of the attendants in these hospitals—and these are representative of the hospitals in the country—were of conscription age and that the average would be over 50 per cent. We placed the matter before the Council of National Defense and the War Department, and a tentative scheme was outlined whereby men who are on duty in the state hospitals may be conscripted but if so they may be furloughed to their hospital and remain on furlough so long as they remain on duty. If for any reason they leave then the War Department is to be notified and the attendant is to be taken into the army. While all state hospitals are willing to make sacrifices and to "do

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their bit" in the present great emergency—and by furnishing specially trained physicians and nurses to the psychiatric hospital units, they are doing "their bit"—still it is of the utmost importance that the hospitals be not depleted of their attendants. I would, therefore, suggest that a resolution which I shall read be adopted and a committee be appointed to discuss the matter with those in charge of the conscription.

WHEREAS, Over 50 per cent of the attendants on the wards of the state hospitals for the insane throughout the country are of conscription age, and

WHEREAS, the ranks of the attendants are already badly depleted and further depletion would seriously handicap, if not paralyze the proper care of the patients in these specialized hospitals, and thereby bring great suffering upon a people already under a heavy load, be it, therefore,

Resolved, that the seriousness of the situation be placed before the Council of National Defense and the Department of War and a plan arranged whereby attendants who may be conscripted may be relieved of service in the army so long as they remain at their posts of duty in the hospitals; be it further

Resolved, that the President of the Association appoint a committee of three to present the matter to the Council of National Defense and the War Department, said committee to report to the superintendents of the hospitals for the insane throughout the country the plan agreed to by the Department of War.

DR. BRUSH.—Mr. President, may I ask Dr. Williams if he will modify his first paragraph so as to include such hospitals as the Pennsylvania Hospital for the Insane, for example, making it read "State and incorporated hospitals."

DR. WILLIAMS.—I have no objection to that change.

Dr. Williams' resolutions were then seconded and adopted unanimously.

THE PRESIDENT.—I will appoint as such committee, Dr. Frankwood E. Williams, of New York; Dr. William A. White, of Washington, and Dr. L. Vernon Briggs, of Boston.

DR. HARRIS.—Mr. President, I have a resolution I would like to offer to the Association:

Resolved, That all ex-presidents, of the American Medico-Psychological Association, not already members of the Council are hereby authorized to sit as ex-officio members of the Council at any annual meeting at which they are present.

THE PRESIDENT.—This resolution is before the Association. I may say that we have at every meeting a few of the ex-presidents. Their advice would be of great help to the Association and I would be very pleased to have the Association consider the suggestion.

Dr. Harris' resolution was duly seconded and adopted unanimously.

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THE PRESIDENT.—The next matter for consideration is the report of the committee in reference to the resolution offered yesterday by Dr. Brush, of which Dr. Meyer is Chairman.

Dr. Meyer submitted the following report, which was on motion duly seconded and adopted unanimously:

The report of the committee to consider the appeal of Dr. E. N. Brush for the cooperation of the American Medico-Psychological Association in the organization of psychiatric work in the present war. The committee appointed to consider the most timely and thoughtful recommendations of Dr. E. N. Brush that our Association put itself at the service of the country in the organization of the recruiting service, in the organization of base hospitals and through making provisions for hospital care for the mentally sick soldiers begs to recommend that we cooperate with the war committee of the National Committee for Mental Hygiene. It is moved that our Association urge that Dr. Wm. A. White be added as a member representing psychiatry to the Medical Advisory Committee of the Council of National Defense. Our committee suggests that the President of our Association appoint one member of the Association in each state to cooperate with the war committee of the National Committee for Mental Hygiene in the organization of the available forces and resources in their particular states.

(Signed) ADOLF MEYER, *Chairman.*
HUBERT WORK,
CARLOS F. MACDONALD,
G. ALDER BLUMER,
EDWARD N. BRUSH.

Dr. Woodson moved the adoption of the report.

The motion was duly seconded and the report was unanimously adopted.

DR. PEARCE BAILEY.—Mr. President, I neglected to state that as to the maximum requirements in the army and navy the regulations provide as to age that officers of the reserve corps must not be over 55 in the army or in the navy, 44.

DR. MEYER.—Mr. President, it will be noticed that the Medical Advisory Committee of the National Council of Defense had no representative in psychiatry; it therefore seemed very important to many of us to have that proviso in our resolutions, suggesting that a representative of this Association be added and this will account for the resolution or suggestion that Dr. William A. White be added as a member representing psychiatry in the Medical Advisory Committee of the Council of National Defense. It is perfectly obvious that the man who is present in Washington and who knows the situation so well, is the logical representative of our body in that very important organization.

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THE PRESIDENT.—I believe Dr. Brush has some remarks to make in reference to the reimbursement of Dr. Henry M. Hurd for expenses incurred in the publication of the Institutional History of the Care of the Insane.

DR. BRUSH.—Mr. Chairman and Gentlemen, you are fairly well aware of the situation from the report made through Dr. Blumer. The cost of preparation and printing the three volumes already issued of the History of the Institutional Care of the Insane in the United States and Canada, as Dr. Hurd has stated in his report, was somewhat in excess of the estimated amount. The number of subscriptions was very much below that anticipated. So that the Association under whose auspices this history has been printed is met with the fact that for the three volumes already issued there is a deficit of about $2600, that is, the cost of printing has been $2600 in excess of the subscriptions. Only 400 subscribers have taken the work. The fourth volume is in press. The same number of subscribers for this volume is on the books. The cost of the fourth volume over the amount to be received would be $900, so that it appears the whole deficit will be between $3400 and $3500. This must be met. It must be met because we are supposed to be decently honest, honest enough to pay our debts; but it primarily must be met in order to relieve Dr. Hurd of the natural anxiety of a man who has undertaken the work, contracted for the binding, printing and publication, and who is met by the fact that he will not be able to pay for the cost of the work from the subscriptions. Dr. Hurd and his associates undertook this work solely as agents of the Association but I am quite sure from my knowledge of Dr. Hurd that he feels it is in a way a personal responsibility; and from this I think we should as promptly as possible relieve him. I think anyone here present, a member of this Association who has not already personally subscribed for this very valuable work, should to-day leave with the Secretary, to be forwarded to the publishers, an order for a full set. I believe also that every superintendent here who has not subscribed for the volumes for his hospital library, should do that also. Many of the subscriptions that have come in have been for this, that or the other hospital, the bills to be paid by the hospital. But the superintendent should also own a set, and every assistant physician should own one. There are four or five hundred copies still in stock and if they could be disposed of, the situation would be relieved. I move you that a committee consisting of the incoming President, Secretary-Treasurer, and one other member be appointed to finance the deficit now outstanding and to cooperate with a committee which was appointed by the Council to assist Dr. Hurd in the disposal of the number of volumes remaining unsubscribed for.

DR. S. E. SMITH.—Mr. President, it is my understanding that the Council passed a resolution for the appointment of a committee to take charge of this subject and to dispose of the histories on hand, is that not correct?

THE PRESIDENT.—It is my understanding.

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DR. SMITH.—If that is true, I don't see the need of anyone being added to the committee which was to consist of Dr. Brush, Dr. Hurd and Dr. Herring.

DR. BRUSH.—Mr. President, I don't think that the committee is given any authority to finance the matter. When we dispose of the volumes on hand we can relieve the treasury.

DR. SMITH.—The purpose of the appointment of that committee was to relieve the financial stress and to meet the deficit. The Council appropriated for the purpose $3000 to take care of the deficit. I feel that a more definite statement should be made to the Association or to the Council concerning this matter.

The first statement we heard with relation to this deficit was that it was approximately $2800, the next that it was approximately $3000 and finally that it was $3400. It is impossible to do business in that way. If we have a deficit let us know what it is and meet it. I feel that the committee selected by the Council is competent to handle this question. The Association is obligated and must meet it but let us have all the facts.

DR. BRUSH.—Mr. President, as to the statement of the deficit, that was simply a plain mistake so far as the amount was concerned. The report read by Dr. Blumer stated that the deficit on three volumes already issued and supplied to members was about $2600; I can't remember the definite figures, and that the cost of printing and binding of the fourth volume must be estimated; that can't be definitely stated but upon the basis of the cost of the other three volumes that there would be a total deficit of $3500 to $3600. That fourth volume is not yet completed. For the three volumes completed there is an accurate and definite statement of the deficit.

DR. WOODSON.—Mr. President, I desire to substitute for this motion that the council treat it as it does other bills, pay it off at once and collect for the volumes of the history to be sold as fast as collections are made and so reimburse the treasurer for the outlay proposed. That is an obligation and we must pay it. This committee doesn't mean much unless they are going to pay the deficit from funds already in hand. I move that the Council draw a warrant and pay the debt, and that the Association authorize the Council to reimburse the treasury from the collections aboved referred to.

DR. BRUSH.—Mr. President, I would be glad to accept Dr. Woodson's substitute if the Secretary would satisfy the Association that there is enough money on hand to pay the amount.

THE SECRETARY.—There is not enough money on hand to do it and I don't think that the Secretary's personal check would go.

THE PRESIDENT.—The Treasurer has not enough funds on hand to meet this deficit at the present time.

DR. WOODSON.—Mr. President, the Treasurer seemed to have enough money yesterday.

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THE PRESIDENT.—Yes, but the cost of publishing our transactions will be two or three thousand dollars.

The resolution of Dr. Brush was lost.

THE PRESIDENT.—The matter now remains in the hands of the original committee.

DR. WOODSON.—How much money can be applied at this time?

THE PRESIDENT.—It is impossible to say that. We haven't received all the bills but it is likely that the balance on hand will be as much as $3000.

DR. WOODSON.—Can't that be spared?

THE PRESIDENT.—We have no bill for the publication of the transactions nor have we enough to cover other expenses incidental to the cost of the meeting.

DR. WOODSON.—Can the Treasurer spare $2500.

THE PRESIDENT.—Yes.

DR. WOODSON.—I move that the Association pay $2500 from the funds in hand with the assurance that the remaining volumes be offered for sale and that every member of the Association make it his duty to assist in disposing of them.

DR. S. E. SMITH.—Mr. President, the Association has already authorized the payment of $2500 from the resources of the Association and $500 from the JOURNAL OF INSANITY, so that this motion, if passed, will simply confirm the action taken by the Council on that subject. I think the Association may rest at ease about the matter. I think this committee will take all necessary steps to care for it.

THE PRESIDENT.—If there is anything to be done about the motion of Dr. Woodson it will require a second.

There being no second, the President declared the motion lost.

DR. BRUSH.—Mr. President, as I understand it, the committee created by the Council is authorized to pay as much of this debt from the funds of the Association as possible up to a limit of $3000; and to use the funds of the JOURNAL OF INSANITY to supplement this sum up to a limit of $500, if that amount is available.

THE PRESIDENT.—That is my understanding.

The President announced as the next business the report of the Committee on Psychology in the medical schools.

DR. ABBOT.—Mr. President, the work has rather lagged. There is a great deal of detail to the work which the Committee has not completed and I would like to report progress and to ask that the committee be continued.

THE PRESIDENT.—If there is no objection the committee will report progress and the work will be continued.

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The next report will be that of the Committee on Revision of Proposition, by Dr. Owen Copp, Chairman.

Dr. Copp then submitted the report of the Committee.

Preliminary Report of the Committee on Revision of the "Propositions."

The Committee on Revision of the "Propositions" of the Association has found the subject of such magnitude that the preparation of an adequate report for submission this year would have been difficult, but so much doubt has been expressed as to the wisdom of attempting such revision, that it seemed best to the committee to review the history of the "Propositions" and request discussion of the matter.

An authoritative compilation of these "Propositions" was published by the Association in 1876 in a pamphlet of 32 pages. But, as this pamphlet is not readily available to the members, the following references to the "Propositions" as published in the American Journal of Insanity may be of use.

The first "Proposition," relating to the use of restraint, was adopted at the first meeting of the Association in 1844.

In 1848 disapproval of political appointments was expressed (Am. Jr. of Ins., July, 1848, p. 91), and the necessity of adequate, artificial means of indirect heating and ventilation was emphasized. (Am. Jr. of Ins., July, 1849, pp. 66-67.)

In 1851 the Standing Committee on Construction of Hospitals for the Insane presented a series of 26 "Propositions" Relative to the Structure and Arrangement of American Institutions for the Insane," which were unanimously adopted. (Am. Jr. of Ins., July, 1851, pp. 79-81.)

In 1853 a special committee presented a similar series of 16 "Propositions" "Relative to the Organization of Hospitals for the Insane," which were likewise unanimously adopted. (Am. Jr. of Ins., July, 1853, pp. 68-79.) It is stated that both series of "Propositions" embodied "the well-ascertained views of the members of the Association" and "may be received as the authorized exponents of its views."

The first notable division of opinion arose in 1866 after a long discussion of provision for the chronic insane and extension of the limit of capacity of an institution from the original 200, or 250 to 600. The vote on such extension of capacity stood 8 to 6 in the affirmative. Reaffirmation of the "Propositions" with this modification was made by a vote of 9 to 5. (Am. Jr. of Ins., July, 1866, pp. 147-250.)

In 1868 Dr. Isaac Ray presented, substantially in the same form as previously in 1850, "The project of a law regulating the legal relations of the insane" which was unanimously adopted as a "Proposition" of the Association. (Am. Jr. of Ins., July, 1850, pp. 92-96, and July 1868, pp. 141-143.)

In 1869 the conviction was expressed that religious services of some kind should be regularly held in institutions for the insane. (Am. Jr. of Ins., Oct., 1869, p. 163.)

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The thought and purpose back of these "Propositions" appear from the record that "the Standing Committee on the Construction of Hospitals for the Insane was instructed to report to the next meeting (1851) a series of propositions relative to the structure and arrangements of American institutions for the insane, that would embody the *well ascertained views* of the body in reference to many points in regard to which there was *no difference of opinion.*" (Am. Jr. of Ins., July, 1851, p. 79) and, further, in the preamble to resolutions offered in 1876 by Dr. Ray that "The Association of Medical Superintendents of American institutions for the insane, having been formed for the purpose of promoting the welfare of the insane, regard it as one of their duties to inquire into and pass judgment upon any scheme, project, or change, offered professedly with this end in view. They would be faithless to the trust they have assumed, were they to remain in silence while changes in the management of our hospitals are forced upon us, calculated to impair their usefulness and inflict a positive harm upon their inmates. (Am. Jr. of Ins., 1876, p. 346.)

Pursuant to this purpose and sense of duty of the Association, whenever any important question arose relative to such matters, and, whenever any deviation threatened violation of the principles established by existing propositions, it became customary to reaffirm former utterances, or to formulate new ones to suit the occasion.

In 1870-71 the establishment of the Willard Asylum for the Chronic Insane excited sharp discussion in the Association, exhibiting much diversity of opinion as to the wisdom of separation of the chronic insane in special institutions, but, nevertheless, the propositions were reaffirmed with slight modification. (Am. Jr. of Ins. propositions, Oct., 1870, p. 224; discussion Oct., 1871, pp. 214-219 and 254-258.)

In 1871 didactic and clinical instruction on insanity and medical jurisprudence was recommended to every school conferring medical degrees. (Am. Jr. Ins., Oct., 1871, p. 318.)

In 1872 overcrowding of hospitals for the insane was deprecated and the exclusion of any excess of patients over capacity was recommended to boards of trustees. (Am. Jr. of Ins., Oct., 1872, p. 242.)

In 1873 propositions were unanimously adopted relative to separate provision for insane criminals apart from other insane. (Am. Jr. of Ins., Oct., 1871, pp. 215-237.)

Again in 1874 the propositions were reaffirmed because it had been brought to the notice of the Association that state and county authorities were departing from the "spirit and tenor of the principles" established by it. (Am. Jr. of Ins., Oct., 1874, p. 238.)

In 1876 Dr. Ray offered a series of eleven resolutions against any form of supervision above that of the Board of Managers, or Trustees, of the individual institution, and, particularly, against "supernumerary functionaries" "endowed with the privilege of scrutinizing the management of the hospital," and "controlling" it either "directly by the exercise of superior power" or "indirectly by stringent advice." They were adopted as "Propositions" with two dissenters. (Am. Jr. Ins., Jan., 1876, pp. 245-354.)

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In the same year propositions against the care of inebriates in hospitals for the insane and recommending establishment of separate institutions for them were adopted with a few dissenters. (Am. Jr. of Ins., Jan., 1876, pp. 364-386.)

In 1887, after an interval of 11 years, the Association again appointed a special committee consisting of Drs. Orpheus Everts of Ohio, Daniel Clark of Canada, and Foster Pratt of Michigan, with instructions to "review the propositions and purposes of this Association and report at the next meeting whether any modification should be made." (Am. Jr. of Ins., July, 1887, p. 128.)

In 1888 the report of this committee was made, discussed at length and rejected by a vote of 21 to 13. (Am. Jr. of Ins., July, 1888; report, pp. 50-57; discussion, pp. 127-143; vote, p. 141.) During the discussion a letter from Dr. Pliny Earle was read from which the following extracts are taken:

"By the published program of the proposed proceedings at the meeting at Old Point Comfort, I perceive that 'a report upon the Propositions' adopted by the Association more than thirty years ago, is expected." "I have not been informed of the object in calling for such report, and am, consequently, forced to the inference that it is the intention of the Association to once more take into consideration the utility of those propositions as to what may be called a codified expression of opinion, and, thus, determine the propriety of their future retention.....As one who voted for the original adoption of the first series of those propositions, and who would have voted in favor of the second series had he been present at the meeting when they were adopted, it may not be improper for me to give my present views in regard to them.

"In nearly all human undertakings, promotive measures vary in the different periods of the enterprise, so that, not infrequently, the course pursued in the earlier stages may afterwards become not only ineffective for good, but absolutely detrimental. The 37 years of the existence of the first series of the propositions constituted an era of almost marvellous activity in our specialty, and consequently unanticipated growth and expansion of it in every direction. Experience has been gained, circumstances have been altered, new views have been promulgated, opinions have been reversed or modified, and hence the propositions have to a very considerable extent been disregarded.

"Among those whose opinions have undergone a change I must place myself. Nor is this change, in some respects, of a recent origin." . . . .

"But in my opinion, one of the greatest, perhaps *the* greatest objection to the 'Propositions,' as an embodiment of the views of the Association, is the influence, whether just or unjust, which they have exercised upon public opinion. I most fully believe that they have constituted the principal factor among those agencies which, in some sections of the country, have greatly impaired the prestige which the Association once enjoyed, by engendering a belief that it is practically averse to progress in improvement;

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that it is running in the 'cast iron ruts' of precedent, that it is indissolubly bound to the faith of the fathers, despite the enlightenment of more recent observation, experience and thought. It is to be feared that the direct benefit of the 'Propositions' to the cause, which they were intended to promote, has been more than counterbalanced by the indirect detriment thus produced."

In summing up the discussion Dr. W. W. Godding said, "So then, of the seven survivors of the meeting of the Association in 1851, when the original 'Propositions' were adopted, all will have been heard from but Dr. Stokes.

"The unanimity of sentiment of that earlier day has given place to a diversity of opinion in the very men who framed these 'Propositions,' which only a practical experience in their working could have brought about. With this result, varying surroundings and conditions have had much to do, and the lesson we may learn from it is, that good men, equally earnest, and alike sincere in their desire to make the best provision for the insane, may honestly arrive at conclusions almost diametrically opposite concerning them. This teaching, and may we not also add, as another lesson that line of the old Latin,

'Quieta non movere.'

"'Not to move things at rest?' If we now attempt the revision of the 'Propositions,' or to add what seem self-evident truths to us, will 37 years hence see our survivors any nearer unanimity respecting them than are the survivors to-day?"

Such, in the main, is the history of the "Propositions." Your committee has no suggestion to make, but desires to carry out the wishes of the Association.

Mr. President and members of the Association, we would like your opinion whether it is wise to go on further with this work. It is the unanimous feeling of the committee that they want to do what the Association wants done.

Dr. Blumer.—Mr. President, I am sure we are very much obliged to Dr. Copp and his committee for the very interesting and excellent report here presented. At the same time, most of us will feel, after considering the general subject of "Propositions," that it was a pity to impose this thankless task upon a man possessing Dr. Copp's talents. We are all aware that although the Doctor is not a member of the Society of Friends, he represents a Quaker institution, and so I am reminded of something that happened in Rhode Island in the time of George II, during the colonial governorship of Gideon Wanton. The governor had a kinsman, one William Wanton of Scituate, a Quaker, who had fallen in love with a young woman who was a Congregationalist. Not being able to marry out of meeting, William said to his beloved: "Friend Ruth, let us break from this unreasonable bondage—I will give up my religion and thee will give up thine, and we will join the Church of England and go to the devil together."

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Now, gentlemen, it seems to me we have a situation here that has a bearing on this report. We don't want to rivet bonds upon this Association at this time—that would be an anachronism; rather let us think of "Liberty Bonds" to-day. (Applause.) I for my part—and I am sure I voice the opinion of most of the men of the Association—would rather go to the devil, or its equivalent, as a latitudinarian than endure the bondage of any "Propositions," either ancient or modern.

I therefore move you, Mr. President, that the report of the committee be received with gratitude and that the committee be discharged.

THE PRESIDENT.—Before putting the motion I would like to say that when the speaker referred to the misuse of the talents of the Chairman of the committee on this work, he looked twice at your President. Your President declines all responsibility, for that committee was appointed by his predecessor. (Laughter.)

The motion of Dr. Blumer was duly seconded and unanimously adopted.

DR. BRUSH.—Mr. President, I would say that your predecessor appointed the committee upon the request of the Association and not because he believed in the general proposition himself.

THE PRESIDENT.—We have a Committee on Immigration of which Dr. Brush is Chairman. Can we have a report from that committee?

DR. BRUSH.—Mr. President, as all the members are aware the Immigration Law was passed by Congress, vetoed by the President because of the illiteracy clause, but again passed over the President's veto.

The new law will greatly improve conditions relating to preventing insane and mentally defective aliens coming into the country, and will facilitate the deportation of many now here. When the war is over it will be in more active operation and its working value can be then tested.

This Association was early in the field in the endeavor to secure better regulations of immigration and has by various committees done much to bring about the enactment of the present law. The previous reports of the present committee will show some of the work done. No further duty remaining I move the committee be discharged.

The motion, duly seconded, was adopted.

THE PRESIDENT.—The hour is late; we have done a large amount of important business. Yesterday at the close of the morning session there were three or four papers that were unable to reach, one by Dr. Wholey, one by Dr. Orton, one by Dr. Cotton and his associates. It is the opinion of the President that that part of the program should be omitted now and that we should proceed with the regular program for Thursday morning. If there is no objection we will begin this morning by hearing a paper on "Mechanism and Treatment of Exhaustion," by Frank P. Norbury, M. D., of Jacksonville, Ill.

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As Dr. Norbury was not in the room the President announced that the next paper, "Physiotherapy," would be read by J. Clement Clark, M. D., of Sykesville, Md.

At the close of Dr. Clark's paper, the President announced that discussion was in order.

DR. WALTER B. SWIFT, BOSTON.—Mr. President, I would like to call the attention of the Association to a series of exercises that I have originated for the treatment of tremors of different sorts. They have been tried in paralysis agitans with partial help and other tremor conditions as "essential tremor" and can be explained to a nurse in a few hours and applied to hospital patients. The system is too long to be described here, but I will mail reprints describing the system to any who give me an address.

THE PRESIDENT.—I desire to announce that from now on all papers will be limited to 15 minutes in duration, owing to the lateness of the hour and the fact that we have quite a number of papers yet to be read—unless the Association directs otherwise.

The next paper on our program is "The Sterilization of the Insane," by Dr. John A. Reily, of Patton, California. As Dr. Reily does not appear to be present, we will proceed to the next paper, "Results in Treatment of Paresis by Inunctions of Mercury and Drainage of the Cerebro-Spinal Fluid," by Alan D. Finlayson, M. D., of Warren, Pa.

Dr. Finlayson's paper was discussed by Dr. C. B. Burr and Dr. Woodson.

Dr. Woodson moved that Dr. Finlayson be requested to continue his investigations and to make a report at the next annual meeting, which being duly seconded, was adopted.

The President announced the next paper, "Experiments with Pituitrin in the Treatment of Dementia Præcox," by Dr. T. C. Biddle, of Topeka, Kansas. Dr. Biddle being absent the President announced that as several papers had not been read, owing to the absence of the writers, the papers omitted from the program of yesterday would be called for. Dr. Wholey was asked to read his paper entitled, "Revelations of the Unconscious in Cases of Alcoholic Hallucinosis."

Dr. Wholey's paper was discussed by Drs. Wm. A. White, Walter B. Swift, William McDonald, E. E. Southard and Dr. Wholey in closing.

THE PRESIDENT.—The next order of business is the report of the Committee on Diversional Occupation.

This report was presented by Dr. R. H. Hutchings, Chairman.

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The Committee on Diversional Occupation begs to submit its report of the exhibition now on view in an adjoining room. The experience of former years has made evident the fact that in our hospitals for the insane a very high class of work is being regularly turned out by the patients in the occupation classes and it can no longer be disputed that such work compares favorably in quality and will sell for as high a price as similar work made anywhere. The large and beautiful exhibits which were shown at Old Point Comfort and at New Orleans have settled this point beyond question. It, therefore, seemed to the committee that further displays of miscellaneous articles would no longer be of interest but rather the exhibits should be planned to bring out the methods employed in providing occupation in the different hospitals and to show the progress made by individual patients as a result of educational efforts along these lines.

Your committee issued a circular in December inviting participation in the exhibit to be held in connection with this meeting and requested the hospitals to confine their displays to articles which would demonstrate the advantages gained by individual patients as a result of occupation, and suggested that serial pieces be shown and that they be accompanied by an abstract from the clinical record showing the improvement in the mental condition coincident with and presumably due to employment.

Subsequently this was modified to admit three additional classes of articles, namely:

(a) Group work, where several patients co-operated in the making of the article.

(b) Models or drawings of work rooms where patients are employed.

(c) Photographs and other representatives of amusements, diversions and recreations afforded to patients.

The committee believes that in the work of re-education amusements occupy a place no less important than work. The object to be gained is to interest the patients and divert their minds from painful introspection and project them into more healthy channels of interest, and this object can often be gained, or at least a beginning can be made, through amusements and that these should be judiciously combined with occupation to afford the maximum benefit.

The committee is pleased to report that the response of the several hospitals has been most satisfactory and encouraging. The display in an adjoining room is highly creditable and has been greatly enjoyed by all those who have seen it. Displays have been made in all subdivisions and the competition in several of the groups was keen. The President appointed a Board of Judges to pass upon the merits of the several exhibits and made an excellent selection of persons who were thoroughly familiar with the subject and who were not connected with hospitals entering into the competition. The report of the judges has been prepared and I will read it as it has been handed to me by the Chairman, Mr. George A. Hastings.

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Report of the Judges of the Exhibit on Diversional Occupation of the American Medico-Psychological Association, Hotel Astor, New York, May 29 to June 1, 1917.

The committee appointed to judge the exhibit on diversional occupation at the annual meeting of the American Medico-Psychological Association at the Hotel Astor, May 29 to June 1, 1917, reports that after painstaking inspection and examination it has reached the following conclusions:

Private or semi-private institutions best illustrating (1) Progress made by individual patients, (2) Group work, (3) Work rooms, (4) Amusement, diversions or recreations—Bloomingdale Hospital, White Plains, N. Y.

Public hospital best illustrating all four points above enumerated—Allentown State Hospital, Allentown, Pa.

Public hospital best illustrating progress made by individual patients—St. Lawrence State Hospital, Ogdensburg, New York.

Public hospital best illustrating group work—Allentown State Hospital, Allentown, Pa.

Public hospital exhibiting best figures or models illustrating work rooms—Allentown State Hospital, Allentown, Pa.

Public hospital exhibiting best schedule showing the number of forms of amusements, diversions or recreations—Binghamton State Hospital, Binghamton, N. Y.

HONORABLE MENTION.

The committee would also award honorable mention to the following institutions:

To the Pennsylvania Hospital—for the best articles illustrating the greatest progress by an individual patient in a private institution.

To the Napa State Hospital, California, for the most remarkable group of articles illustrating progress by an individual in a public institution.

To the Sheppard and Enoch Pratt Hospital, Maryland—for its exhibit of group work in a private institution.

To the Columbia State Hospital, South Carolina—for general excellence of its exhibits as indicating progress in diversional occupation work within a short period since its inauguration at the institution.

CERTIFICATES OF EXCELLENCE.

The committee would also award the following certificates of excellence:

To the Bloomingdale Hospital—for graphic charts effectively indicating and displaying the growth and development of its diversional occupation.

To the Sheppard and Enoch Pratt Hospital—for pleasing results obtained with simple designs, colors and materials.

Pennsylvania Hospital—for definite and orderly arrangement of a display for interesting and educating the public.

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The judges desire to record their impression that the entire exhibit is unusually effective, attractive and well calculated to stimulate interest and results in diversional occupation.

Respectfully submitted,
GEORGE A. HASTINGS, *Chairman*,
MISS SUSAN C. JOHNSON,
FRANKWOOD E. WILLIAMS, M. D.,
WILLIAM W. RICHARDSON, M. D.,
JESSE COGGINS, M. D.

At the close of the report on motion duly seconded and adopted, it was accepted and placed on file.

The President announced a Council meeting to be held shortly after adjournment to which ex-presidents of the Association would be cordially welcomed. He also announced that the excursion about the city in automobiles for the visiting ladies would start from the Hotel Astor at 2.30 p. m.

AFTERNOON SESSION.

THE PRESIDENT.—The last paper on the program before luncheon was to have been read by Dr. L. Pierce Clark of New York City, on "Extra-Asylum Psychiatry." I was under the impression that the Doctor was not here but learned subsequently that he was in the room and that he would like to have an opportunity of presenting a short paper to the Association. I will first call for the report of the Council.

At a meeting of the Council held May 31, the following were recommended for associate membership:

Dan S. Renner, M. D., Skillman, N. J.; John V. Donner, M. D., Morris Plains, N. J.; De Land B. Alford, M. D., Boston, Mass.; Catherine MacPhee, M. D., Boston, Mass.; Christine Leonard, M. D., Boston, Mass.

Respectfully submitted,
H. C. EYMAN, *Secretary*.

THE PRESIDENT.—The applications for associate membership will lie on the table until to-morrow morning when they will be called up for action.

Dr. L. Pierce Clark then read his paper which was discussed by Drs. Rosanoff, Abbot, Harris, Russell, W. B. Swift and Dr. Clark in closing.

The Chair then announced the next paper by Dr. L. Vernon Briggs, Boston, Mass., "Occupational and Industrial Therapy." This paper was discussed by Drs. W. L. Russell and Woodson and Dr. Briggs in closing.

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A paper entitled "A Sociological Study of a Group of Prostitutes" was then read by Dr. Jau Don Ball, Oakland, California.

There being no discussion the next paper, "Psychiatry and the Problem of Feeble-Mindedness," by Dr. William B. Cornell, of New York, was announced. Dr. Cornell not being in the room, the next paper, "Institutional Inefficiency," by Dr. W. M. Hotchkiss, of Jamestown, N. D., was called for.

Dr. Hotchkiss not being present the next paper was read by Dr. J. J. Kindred, of Astoria, L. I., "Eugenics—its Relation to Mental Disease."

There being no discussion of Dr. Kindred's paper the President announced that the program would be varied somewhat and that a paper announced for Friday, "The Toxic Psychoses," would next be read by Dr. G. W. Brown, of Williamsburg, Pa.

There being no discussion of Dr. Brown's paper, the President announced adjournment until 8 o'clock p. m.

Evening Session.

The President announced as the first paper of the evening session, "Mental or Brain Hygiene," by Dr. J. T. Searcy, of Tuskaloosa, Ala.

After the close of Dr. Searcy's paper, the President announced as the next paper, "The Importance of Out-Patient Work Among the Insane," by Dr. A. W. Stearns, of Boston, Mass. Dr. Stearns' paper was discussed by Dr. Briggs, Dr. Ostrander, the President, Dr. Wagner, Dr. Pilgrim, Dr. Houston and Dr. Stearns in closing.

The President announced as the next paper, "Psychopathic Building and Receiving Service," by Chas. A. Barlow, of Spencer, West Virginia.

Before reading his paper Dr. Barlow said:

Mr. President, Ladies and Gentlemen: Before beginning my paper I wish to say that I have nothing new or startling to offer and I expect Dr. Harrington who is to follow me will give you some newer ideas; but the purpose of this paper is that of bringing before the Association again the advisability of psychopathic or detached buildings for receiving service.

Dr. Harris.—Mr. President, I notice the paper that is to follow this is somewhat similar and I would suggest that discussion of both papers be taken at the close of Dr. Harrington's paper.

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The President then announced as the next order, a paper by Dr. A. H. Harrington, of Howard, Rhode Island, "Plan and Equipment of a Reception Hospital," illustrated by lantern slides.

DR. HARRINGTON.—*Mr. President, Ladies and Gentlemen:* I am very glad that we have had this paper of Dr. Barlow's which relates to some extent to the subject which I am to present. Dr. Barlow has gone into some matters which are very essential in the treatment of the whole subject. The scope of my paper is somewhat different, as I am dealing rather with the material side of the subject, that is, with a building, its general plan and lay-out, for the purpose of a receiving service in connection with a state hospital for the mentally ill.

As we all realize to-day practical psychiatry is not confined to hospital wards but is state wide and from what we have heard in this hall this very day we may add, it is nation wide; nevertheless practical psychiatry must always possess its institutional background. Therefore I believe that it will be useful to consider one feature which may enter into hospital planning; namely, the providing for the receiving service of a large state hospital for the mentally ill in a separate building, called if you please, a reception hospital, so planned and administered as to constitute a separate unit as far as practicable of the main hospital plan.

Dr. Harrington then read his paper which was illustrated by numerous lantern slides.

In closing, Dr. Harrington said:

I want to say that in regard to administration and organization of this separate unit of our hospital, we have had to work that out for ourselves, as we have had no available precedents to follow. In regard to the building, however, I want to acknowledge our indebtedness to Dr. Charles P. Bancroft who had personally built a reception hospital building at New Hampshire State Hospital and who was of great assistance both to our architects and myself.

The President then announced the discussion of the two papers in order.

The papers of Drs. Barlow and Harrington were discussed by Drs. C. G. Hill, Harris, J. C. Mitchell, Ostrander and Dr. Harrington in closing.

The President announced as the last paper of the evening, "General Consideration of the care of Epileptics," by Dr. Everett Flood, of Palmer, Mass.

This paper was profusely illustrated with slides.

Dr. Flood in introducing the paper said:

I have almost nothing to offer except the presentation of these pictures and I believe I can properly show what has been done in the care of the

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special types of epileptics. I don't pretend that we have anything particularly fine but only something to illustrate the facts.

At the close of Dr. Flood's paper, the Association adjourned until 10 a. m. Friday.

FRIDAY, JUNE 1, 1917.

The President called the Association to order at 10 o'clock.

THE PRESIDENT.—We have completed our program up to the close of Thursday evening leaving us only the papers and other general business scheduled for Friday morning.

In a report submitted by the Council yesterday morning, the applications for associate members were submitted:

Dan S. Renner, M. D., Skillman, N. J.; John V. Donnet, M. D., Morris Plains, N. J.; De Land B. Alford, M. D., Bos[illegible]n, Mass.; Catherine MacPhee, M. D., Boston, Mass.; Christine Leonard, M. D., Boston, Mass.

Dr. S. E. Smith moved that the Secretary cast one ballot providing for the election of these physicians as recommended by the Council.

The motion was seconded and adopted.

THE PRESIDENT.—I will read an interesting telegram received this morning from Dr. Chapin and which was sent in response to the telegram of our Secretary yesterday congratulating him on having been a member of this Association for 50 years:

CANANDAIGUA, N. Y., May 31, 1917.

Dr. H. C. Eyman, Secretary, Hotel Astor, New York.

Many thanks for telegram from your Association. What changes in the care of the insane I have witnessed since my first visit to its New York meeting in 1852 as a visitor, which first inclined my mind to enter its service. Now, I am quite well and retired. No one asks my opinion about anything.

(Signed) JOHN B. CHAPIN.

THE PRESIDENT.—I would now call for a report of the Committee on Resolutions.

Dr. Work, as chairman of the committee, submitted the following report:

REPORT OF COMMITTEE ON RESOLUTIONS, JUNE 1, 1917.

DR. WORK.—Mr. President, your Committee on Courtesies recalls that 57 days ago when the to-be members of your Committee on Resolutions read our declaration of war against Germany, it was jubilant and voiced many vainglorious expressions intended to indicate patriotism.

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This attitude was accentuated when we read the uncomplimentary pronouncements of the President of the United States against the Kaiser; even holding his ancesters responsible through hereditary transmission for him and his mannerisms of warfare.

Then the remembrance came to us that almost immediately this Association must hold its annual session on the water's edge nearest to this seeming enemy of all mankind with nothing but Josephus Daniels, to quote General Goethals, between us; and he deep in the woods hunting for "nesting trees for shipbuilding."

Those of us until that moment who believed ourselves securely lodged among the spinous processes of the Rockies, the backbone of our continent, were terrorized, and the vagrant thought of failing in our duty to this Association by industrious flight or intensive home industry was seriously entertained.

But we bought a Liberty Bond, a family burial plot, and, like Israel Putnam, left the cattle yoked to the plow and set our faces resolutely towards the rising sun.

As we neared this cosmopolitan center of uncensored sin our despairing terror increased. Our childhood imagery of devilish physiognomy gradually assumed the cartooned features of a great but misguided ruler wearing a spiked helmet emblazoned thereon "Wilson, that's all."

The signs by the roadside did not reassure us that he might not want more. Utterly disorganized, we believed that the eye of a periscope could wring confessions from us of sins never committed, and I will submit that men less brave would have collapsed en route.

But once arrived, we grasped the outstretched welcoming hands of the Clan MacDonald, its chief the hero of wars now history, restless to enter wars to come, serenely conscious of the triumph of any cause made righteous by the adherence of Scotland. His efficient complacency restored our wavering faith in the doctrine of fore-ordination and brought us peace.

We found one of the Pilgrims yet here to reassure. Herring and Salmon had been provided, the Haviland laid, a Copp on guard, and the Hurd was soon in readiness to start Southard to newer fields of achievements over the great White way.

The Burrs stuck a mite more closely perhaps because of our common menace, but we were not Meyered as we went Anglin for pleaures among the Hills, or chose to Wade through myriads of bright lights in quest of diversions.

The Dewey mornings of May greet us, rarely seen in New York, for here day ends on the day after and morning dawns at high noon. Providence sent us the cultured Blumer with flowers of eloquence, scintillating oratory, bursting with fragrance, with no thorn concealed.

The Burgess of the Dominion of Canada, which desires not annexation but to be a sister to us for the time, and Smith from the security of his East Haven—nothing was left to Hancker after for nothing was less

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cordial, less reassuring and nothing amiss, nothing omitted that might even remotely contribute to our enjoyment.

The princely President diffused a melody through every meeting without visible instruments of music, impossible even for the great composer of the same family name, and we congratulate him upon the Association's greatest meeting, scientifically, numerically or in remembrance alone of those selected to guide its future destinies.

Your committee, for the entire membership attending, thanks the thoughtful, kindly and efficient Committee on Arrangements, the management of the Hotel Astor for its hospitality and for the courtesies of its employees; the management of the Manhattan State Hospital for the use of its good ship the *Wanderer,* the bounty of her larder and the civilities of her improvised crew, and we are appreciative likewise to the business men and firms interested in the welfare of the darkened intellect, who were so lavish in expenditure of funds and physical energy for our well-being.

We are about to leave it all, knowing well that we shall return, as all men sometime will, to this great city where welcome always smiles and farewell goes out sighing.

HUBERT WORK, M. D., *Chairman,*
CHARLES G. HILL, M. D.,
JAMES V. MAY, M. D.,
Committee on Resolutions.

THE PRESIDENT.—The report of the committee is before you, what is your pleasure?

DR. WOODSON.—I move that the report of the Committee on Resolutions be accepted and adopted.

The motion of Dr. Woodson was seconded and adopted unanimously.

THE PRESIDENT.—We will now proceed to the regular literary program.

DR. ABBOT.—Mr. President, there is one matter that needs to be cleared up before we go further. The Committee on Statistics rendered a report, a part of which was adopted. A motion was afterward adopted creating a standing committee to continue the work which had been inaugurated. I think no action was taken with regard to the discharge of the first committee, and in order to make the matter perfectly clear I would move that the previous Committee on Statistics be discharged.

The motion of Dr. Abbot was seconded and adopted unanimously.

The President announced as the next order, the reading of a paper by Dr. E. A. Strecker, of Philadelphia, Pa., "Certain of the Clinical Aspect of Late Katatonia with Report of Cases."

There being no discussion of Dr. Strecker's paper, the President announced as the next paper, "A Study of Cases of Manic-

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Depressive Psychoses Arising after the Age of 40," by Ray L. Whitney, M. D., Waverley, Mass.

In introducing his paper, Dr. Whitney said:

Mr. President, I was very glad to have had Dr. Strecker's paper precede mine for he has described some of the onsets of these psychoses which I didn't dare put into print. My paper, however, will be found to deal with much of the matter that he has taken out.

At the close of Dr. Whitney's paper it was discussed by Dr. Wm. McDonald.

THE PRESIDENT.—Is there any further discussion of these papers? If not, I would like at this time to call your attention to the meeting scheduled for this afternoon, the announcement for which appeared in the slip at the end of our formal program. It will be a very important meeting dealing with food supplies, especially those supplies which can be produced on the farms of institutions. The United States Commissioner of Agriculture or rather, the Assistant Commissioner, Hon. Carl Vrooman, has promised to be here at 2.30 o'clock to talk to us on this subject. The Deputy Commissioner of Agriculture of the State of New York, Mr. H. B. Winters, will be here at the same time to address us; as you all very well know the success of the great war for the Allies depends very largely upon how the food question is handled, and we, as superintendents and others interested in this question, should come here and listen to what the Commissioners of Agriculture have to recommend and participate in the discussion; not only our members but visitors—all will be gladly welcomed in this room at 2.30 p. m.

The next paper in order is "The So-Called Lucid Interval in Manic-Depressive Psychoses—Its Medical—Legal importance," by Alfred Gordon, M. D., Philadelphia, Pa.

Dr. Gordon's paper was then read, after which discussion was called for.

The paper was discussed by Dr. G. H. Hill.

THE PRESIDENT.—We have one more paper to present this morning and several to be read by title. The Program Committee showed remarkable foresight or insight of some kind, which enabled them to determine exactly what we could do at this meeting. The meeting is expected to terminate at noon and the next paper will take exactly the remaining 15 minutes, we shall therefore complete the program in the time allotted for it.

The following papers will be read by title:

"Focal Infections," by Carl W. Sawyer, M. D., Marion, Ohio; "Impulsive Acts, in the Form of Swallowing Foreign Objects, with a Report of four Unusual Cases," by A. W. Hosholt, M. D., Napa, California; "What Personal Attention Means to the Patient," by H. J. Gahagan, M. D., Elgin, Illinois; "Complement

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Deviation Tests for Tuberculosis in the State Hospitals," by E. T. Gibson, M. D., Middletown, Conn.; "Some Suggestions on Pathology and Treatment of Alcoholism," by Chas. G. Hill, M. D., Baltimore, Maryland; "Military Training in Public Schools as a Prevention of Mental and Physical Delinquency," by H. G. Sights, M. D., Paducah, Kentucky; "Diet in Psychiatry," by Dr. Tom A. Williams, Washington, D. C.

We will next have the paper, "Malingering: A Problematical Case," by Dr. William C. Sandy, Columbia, S. C.

At the close of Dr. Sandy's paper it was discussed by Dr. C. F. MacDonald.

THE PRESIDENT.—*Ladies and Gentlemen of the Association:* The literary program of this session is now concluded. Is there any further business to be transacted?

If there is none, the hour has arrived for the closing scene of what I think may fairly be termed the best meeting we have had in the entire history of this Association. The scientific papers presented have been uniformly of high character, the discussions have been interesting and highly beneficial to us all. The scientific, educational and occupational exhibits in the adjoining hall have been very fine indeed. The attendance has been exceptionally large—I think fully 500, the register shows 418—which is by far the largest we have ever recorded. The hall provided for our meetings has been unusually well situated in that it has been free from noise and disturbances which have troubled us quite a little at some of our other meetings. The many distractions of this great city with all their alluring magnetism have not interfered with this meeting for our sessions have been the best attended that I have ever seen in an experience of 30 years. Perhaps the all-wise Providence, that watches over everything, helped us to some extent in this respect by sending frequent and copious rains that made it more comfortable to stay inside than to wander abroad—at any rate, I think all who have participated in our sessions, as they have progressed, will agree with me that the seventy-third annual meeting of this Association has been a success. It now remains for me to perform the pleasant duty of inducting into office my successor, Dr. James V. Anglin, of St. John, New Brunswick, and I will ask Dr. Clark, of Maryland, and Dr. Burr, of Michigan, if they will kindly escort Dr. Anglin to the Chair.

Addressing Dr. Anglin, President Wagner said:

Dr. Anglin, you have been called to the highest office in the gift of this Association. Your fellow members have placed upon you the hall-mark of sterling silver and I but voice their sentiments when I say to you that our members one and all have the utmost confidence in your ability to safely guide this Association through the coming year and to make the meeting of 1918 better, larger, stronger and more successful than any

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of its predecessors. You come from the Dominion of Canada on the other side of the St. Lawrence River. We of the United States have long looked upon you and your people as our friends and neighbors; but now, in the great struggle, in which you as well as ourselves are engaged not only for self-protection but for the common good of humanity throughout the world, a closer tie binds us that I trust may never be broken. Remembering our common ancestry, our high aims and our unity of purpose, let us henceforth fight our battles together shoulder to shoulder, "never more to walk alone."

In turning over to you the affairs of the American Medico-Psychological Association, it affords me great pleasure to hand you this gavel, the emblem of your office, and to assure you of the cordial and hearty support of every member in all your undertakings.

Upon assuming the Chair, Dr. Anglin said:

Dr. Wagner, I thank you for your generous words. To my sponsors I am grateful for their support much needed at this hour. To the members of this Association, I am proud to occupy this place and I thank you for the honor. I must detain you a few minutes longer in session as there are some committees that should be named, especially this year. The most important business at this moment is to remind you of the meeting to be held this afternoon on food production, as you know in wartime, food is as necessary as men.

As to the appointment of committees, the committee on Scientific Exhibit and Pathological Investigation stand as in former years. The Committee of Arrangements will consist of Drs. Sanger Brown, Richard Dewey, Geo. A. Zeller, H. G. Gahagan, H. Douglas Singer, Frank Norbury, Sidney A. Wilgus, S. E. Smith and H. C. Eyman.

The Committee on Diversional Occupation will consist of Dr. R. H. Hutchings, Chairman; Dr. Jesse C. Coggins, Dr. William W. Richardson, Dr. William Rush Dunton, Dr. H. G. Gahagan.

The Committee on Program will consist of Drs. H. W. Mitchell, E. E. Southard, Sanger Brown, Alfred T. Hobbs, Henry C. Eyman and George H. Kirby.

The Committee on Statistics will consist of Drs. Thomas W. Salmon, Adolf Meyer, Albert N. Barrett, E. Stanley Abbot, George H. Kirby, Owen Copp and James V. May.

The Committee of Superintendents or other representatives to cooperate with the National Committee for Mental Hygiene and National Council of Defense will consist of the following: Dr. Burr, of Michigan, Chairman; Alabama, James T. Searcy, M. D.; Arizona, Alfred C. Kingsley, M. D.; Arkansas, James L. Green, M. D.; California, Jau Don Ball, M. D.; Colorado, Hubert Work, M. D.; Connecticut, C. Floyd Haviland, M. D.; Delaware, W. H. Hancker, M. D.; District of Columbia, William A. White, M. D.; Florida, Ralph M. Greene, M. D.; Georgia, Henry D. Allen, M. D.; Idaho, John W. Givens, M. D.; Illinois, George A. Zeller, M. D.; Indiana, S. E. Smith, M. D.; Iowa, W. P. Crumbacker, M. D.; Kansas, Thomas Biddle, M. D.; Kentucky, H. B. Sights,

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M. D.; Louisiana, Clarence Pierson, M. D.; Maine, Forrest C. Tyson, M. D.; Maryland, Edward N. Brush, M. D.; Massachusetts, Henry R. Stedman, M. D.; Michigan, C. B. Burr, M. D.; Chairman; Minnesota, C. Eugene Riggs, M. D.; Mississippi, J. M. Buchanan, M. D.; Missouri, C. R. Woodson, M. D.; Montana, J. M. Scanland, M. D.; Nebraska, W. S. Fast, M. D.; New Hampshire, Charles P. Bancroft, M. D.; New Jersey, Henry A. Cotton, M. D.; New York, Charles G. Wagner, M. D.; North Carolina, Isaac M. Taylor, M. D.; North Dakota, W. M. Hotchkiss, M. D.; Ohio, F. W. Harmon, M. D.; Oklahoma, John M. Duke, M. D.; Oregon, Henry Waldo Coe, M. D., Pennsylvania, Henry A. Hutchinson, M. D.; Rhode Island, G. Alder Blumer, M. D.; South Carolina, C. F. Williams, M. D.; South Dakota, L. C. Mead, M. D.; Tennessee, James J. Neely, M. D.; Texas, John Preston, M. D.; Utah, George E. Hyde, M. D.; Vermont, Shailer E. Lawton, M. D.; Virginia, William F. Drewery, M. D.; Washington, Robert P. Smith, M. D.; West Virginia, Charles A. Barlow, M. D.; Wisconsin, Richard Dewey, M. D.; Wyoming, Charles H. Solier, M. D.; Canada, Dr. T. J. W. Burgess, M. D.

PRESIDENT-ELECT ANGLIN.—*Gentlemen of the Association:* Now that my hour has come, without being told I know that I shall have the sympathetic assistance of every member of the Association, the officials, past, present and future ones, and, of course, in this Republic, that includes all.

I do not expect to occupy fully my predecessor's shoes but I shall do my best to keep up the pace set. We cannot mark time. No matter what other business may be abandoned in these troublous times the unfortunates entrusted to our care must not be neglected, not only for their own good but that of the community. The Canadian military act grasps this when it exempts from military duties the staffs of institutions for the insane.

Unworthy as I am to occupy this, the most exalted position in your gift, I appreciate more than words can convey the honor conferred on me and on my country.

Now that this great Union has entered into the conflict to preserve civilization, it seems more than a coincident compliment that one who owes allegiance to the flag that has braved the battle and the breeze for centuries should be acclaimed President of this Association, beneath the folds of that younger banner which has ever been unfurled in service to mankind.

While here we have witnessed the observance of your Decoration Day. Your sister country to the north must soon institute hers. The cream of our youth are spending themselves for us on foreign soil.

In the past we have been wont to speak of worthy sons of worthy sires. We must reverse that now. Our boys are falling for us like heroes even as we speak. The greatest inspiration in life for better things comes to us from the supreme sacrifices they are making on behalf of all that they hold dear.

May we prove worthy!

I would suggest that we all join in singing "America." Dr. Ostrander will be good enough to lead us on the piano.

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At the close of the singing the President said:

Gentlemen: Reluctantly I declare the Seventy-third Annual Meeting of the American Medico-Psychological Association concluded.

The final session was then brought to a close at 12.15 p. m.

H. C. EYMAN,
Secretary.

NOTE.—The special afternoon session was well attended and the address of Hon. Carl Vrooman, Assistant Secretary of Agriculture, was received with marked attention and provoked an interesting discussion. By resolution the address was ordered printed and distributed to the members of the Association. The address has been printed by the Sheppard Hospital Press, and distributed by mail from the hospital. Additional copies may be obtained from the Secretary, Dr. Eyman.

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PRESIDENTIAL ADDRESS.

RECENT TRENDS IN PSYCHIATRY.

By CHARLES G. WAGNER, M. D.,
Medical Superintendent Binghamton State Hospital, Binghamton, N. Y.

Members of the American Medico-Psychological Association, Ladies and Gentlemen: The Association is now assembled for its seventy-third annual convention; its members are gathered for a meeting under extraordinary circumstances: our country is at war with a great foreign power; our national government, after long and careful deliberation, has reluctantly entered the titanic world-wide conflict on behalf of civilization, national independence and the rights of humanity. In this critical hour, with the nation facing the greatest crisis in its history, with its very existence imperiled, a solemn obligation rests upon every loyal American citizen; an obligation to support the government of the United States with all the resources at his command, and to render faithful and efficient service wherever duty calls him.

Our country is confronted with grave problems: a vast military organization must be created; unlimited financial credit established; war munitions manufactured on an enormous scale and food supplies in huge quantities must be provided, not only for our own people, but for hungry millions beyond the seas. The food question is the most important of all these problems, and the members of this Association can aid materially in its solution by devoting their energies to the task of making every institution possessed of farm lands largely self-sustaining as regards the products of the soil and the food supplies derived therefrom. This subject will be discussed by Hon. Carl Vrooman, Assistant Secretary of Agriculture, and others whose expert knowledge qualifies them to speak of the urgent need of strenuous and intensive farm cultivation, at a special session set apart for it, and to which you are cordially invited.

Fifty-three years ago when our Civil War was at its height, at their meeting in Washington, our members tendered their services

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to the Surgeon-General of the United States to aid in the care of sick and wounded soldiers in the hospitals attached to the battle-fields. The need of such aid, especially in the domain of psychiatry, may again become exceedingly urgent in the near future. At this meeting, therefore, at an opportune time I shall offer a resolution covering a tender of similar service, and I trust it may have your unanimous and enthusiastic approval.

For the sixth time in three-quarters of a century our meeting is held in the city of New York, where its importance is accentuated by the unprecedented demand for place on its program by members who seek opportunity to be heard in the greatest forum of the world; indeed their offerings have been so numerous that many papers which the Association would be glad to hear in full must be read by title only, as limited time will not admit of their full presentation.

To be your presiding officer at this meeting I esteem a very great privilege; to be the President of this Association, to occupy the chair so ably filled by many distinguished predecessors, is indeed the greatest honor that has ever come to me, and I should be unmindful of my nearest duty if I failed to express my obligation to you my fellow-members for the distinction you have conferred upon me, and my appreciation of your very kind consideration, but along with a profound sense of gratitude comes deep humiliation born of the feeling that any effort on my part to address you as becomes the great office I hold, must appear poor indeed when placed in deadly parallel with the scholarly productions of my predecessors whose names are a brilliant galaxy in the scientific firmament of psychiatry.

To that great array, the empire state has contributed a splendid share; the names of Nichols of Bloomingdale, Gray of Utica, Andrews of Buffalo, Chapin, Wise, Blumer, the MacDonalds, Brush and Pilgrim, together with many of equal eminence from other states and from Canada, will always be an inspiration to those coming after them. But, notwithstanding that inspiration, it requires but a brief survey of the pages of the AMERICAN JOURNAL OF INSANITY in which our presidential addresses have been published, to disclose that misgiving, doubt, anxiety and despair have been in turn the controlling emotions of nearly every one who has essayed the task of preparing the president's

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address for an occasion like this, since that memorable day when Dr. John H. Callender of Tennessee, broke the ice at Newport, with the first attempt in 1883, and then, only, after solemn assurance from the Association that his utterance should be immune to all discussion.

Even the erudite sage of Butler, whose facile pen knows no peer, was moved to say at Washington, a decade or so ago, that "for a whole year such a thing as serenity of soul is unknown to the man who awakes to find greatness accidentally thrust upon him as president of an association like this. From that moment of initial apprehension to this one of extreme anxiety, the thought of delivering the annual address haunts him during every waking hour, and even racks his subconscious mind while he seems to sleep o'nights." Well-nigh every imaginable subject that might appear worthy of your consideration at this time has been traversed and re-traversed in days gone by until scarcely an undissected fragment remains for further discussion. I trust, therefore, I may be pardoned if I ask your kind indulgence while I offer a few brief, and I fear rather trite comments on what may be termed some of the recent trends in the domain of psychiatry.

The activities of this Association cover a period of 73 years; it is older than any other national medical organization on this continent; from the small gathering of 13 superintendents at the residence of Dr. Kirkbride in Philadelphia, in the month of October, 1844, it has grown until to-day nearly every public and private institution for the care of the insane in the United States and Canada is represented on its roster, and our membership has nearly reached the one thousand mark. Our organization to-day includes, as it has in the past, the ablest men in our profession, devoted to the study of mental and nervous diseases, and the good work that they and those who have preceded them have done to alleviate the conditions surrounding the insane is an enduring monument to their industry, self-sacrifice and devotion to duty.

The history of insanity is voluminous. The scriptural references of the Old Testament; the early beliefs in demoniacal possession; the advent of Hippocrates and his gentle ministrations; the lapse of the world into the barbarism of the "Middle Ages" and the coincident reign of witchcraft and sorcery; the cruel tortures that terminated the lives of thousands of unfortunate

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sufferers, guilty of no greater crime than the loss of their reason; the coming of Pinel, Tuke, Connelly and other humanitarians and the revolution in the method of treatment that resulted from their enlightened teaching, have all been exploited before you by abler pens than mine on many occasions. The early history of the insane in this country; the great advances in psychiatry, in hospital administration and in constructive development, are all matters of record in our proceedings and transactions in such detail as to scarcely need mention at this time. This great field has been especially covered by the monumental work of the committee of which my distinguished colleague and former President of this Association, Dr. Henry M. Hurd, is chairman, in the splendid history "The Institutional Care of the Insane in the United States and Canada," which has been issued from the press within the past year.

Wide and favorable comment has been made on this great work, for which the Association may claim some credit in that it assumed sponsorship for the enterprise in 1908 at Cincinnati, by directing its President to appoint the committee charged with the duty of preparing it, and by assuming financial responsibility for its publication. The four volumes of this history, comprising more than 2500 printed pages, constitute a library for the student of psychiatry, and to Dr. Hurd and his immediate associates in this great undertaking, performed without other reward than the satisfaction derived from the consciousness of a noble task splendidly done, are due the thanks not only of our Association, but of the entire medical profession.

The cordial reception this publication has met with is an encouragement to the Association to undertake another important task, the successful accomplishment of which would be of great value to the medical profession, namely, the formulation and adoption of a uniform classification of mental diseases, and the publication annually of a statistical report of the insane, showing the status of insanity in every state in the union. This is unquestionably a work our Association should undertake rather than some other organization having no direct connection with the care and treatment of the insane, and I bespeak, therefore, your hearty approval of the report of the committee on uniform statistical reports, advance copies of which have been placed in your hands.

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The American Public Health Association through its committee on "Relation of the 1920 Census of Vital Statistics" will recommend "that a registration area for institutional medical statistics be maintained for the census year 1920 to include specific mention of mental diseases in the care of institutions." It has been suggested that the American Medico-Psychological Association appoint a committee on "Registration Area for Mental Diseases," and that this committee "recommend a system of classification, secure the support and cooperation of the hospitals, and offer to the Surgeon-General of the United States Public Health Service forms for a series of simple tables to show important data concerning patients with mental diseases admitted to and cared for by institutions during the census year 1920." It is urged that the service could then, and perhaps annually thereafter, publish comparative statistics of mental diseases in the several states and summary statistics for the entire area of registration record.

At the present moment perhaps no phase of psychological medicine is receiving more attention than mental hygiene; this term covers a wide field, including the practical care and treatment of mental diseases and mental deficiency, and the application of psychiatrical and psychological knowledge to social, industrial and economic problems. As the new journal "Mental Hygiene"[1] aptly says: "To-day a general realization is coming into existence that mental factors underlie not only inability to make a living and the gross disorders of conduct, but all the social activities of man." Mental hygiene is by no means a new topic to this Association; it was ably discussed by Dr. Isaac Ray[2] at the meeting in Quebec more than half a century ago, and recently has received careful attention at our Baltimore and New Orleans meetings, and elsewhere at our annual gatherings. At Baltimore three years ago a resolution declaring it to be the duty of every community to properly care for its mental defectives, and of every state and country to enact adequate laws for the proper segregation of feeble-minded persons and the prevention of propagation of their

[1] Mental Hygiene, quarterly magazine of the National Committee for Mental Hygiene, New York, January, 1917.

[2] Mental Hygiene, by Isaac Ray, M. D., Meeting of the Association of Medical Superintendents of American Institutions for the Insane, Quebec, 1858.

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kind, was presented by the President, Dr. Carlos F. MacDonald, and adopted by the Association. This action was unquestionably a step in the right direction, but it was only the beginning of activities on the part of this Association which should be extended and far-reaching in a field of the highest importance. The influence of this great body of specialists in mental and nervous diseases should be constantly exerted along the lines of Dr. MacDonald's resolution, and especially in the domain of childhood, where, as Dr. Meyer has clearly shown, unhygienic surroundings and faulty educational methods are responsible for a large proportion of feeble-mindedness and insanity, especially of the præcox type. From this class of unfortunates the ranks of crime, immorality, prostitution and insanity are constantly recruited. If these defectives are early recognized, as Dr. Pilgrim,* Chairman of the New York State Hospital Commission, has pointed out they can be, by the Binet-Simon and other tests, " and if their future training and education can be directed and regulated so as to bring out the best that is in them, and if they can be segregated when improvement cannot be expected, then one of the questions of greatest importance in the prevention of insanity will have been solved." " To point out ' the way that madness lies,' to show the path that leads to sanity and health, to recognize the backward child and to teach him how to make the most of his limited abilities, to discover latent criminal tendencies in the young and to suggest a method of treatment which will overcome them before they become fixed, to correct the habits of those who are ' burning life's candle at both ends ' either by overwork or ' the pace that kills,' in fact to ' minister to the mind diseased ' in every possible way " should be the special mission of the worker in the mental hygiene field.

In the cultivation of this broad field of human interest perhaps no single agency is more active at the present moment than the National Committee for Mental Hygiene. This organization is making systematic surveys in many of our states for the purpose of ascertaining the conditions surrounding all classes of defectives, especially the insane and the feeble-minded, and recommending to the state authorities means for the amelioration of these condi-

* The State's Efforts to Meet the Mentally Sick Halfway, by Chas. W. Pilgrim, M. D., State Hospital Quarterly, Albany, N. Y., February, 1917.

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tions wherever the need for improvement is found to exist. The New York State Charities Aid Association, through its committee on mental hygiene, is actively at work making organized efforts throughout New York State to prevent mental diseases and to secure the establishment of facilities for the earlier discovery and treatment of mental disorders before they develop to serious or hopeless stages.[4]

In this important movement the state hospitals of New York State, Massachusetts, and some other progressive states, are taking an active part. Mental clinics as features of out-patient departments have been established in connection with many of these institutions and at others plans are well advanced and only await necessary funds for their maintenance to complete their organization. The State of New York has encouraged these clinics during the past two or three years by incorporating in the insanity law a clause, authorizing the state hospitals to organize in connection with each institution an out-patient department, of which such clinics are special features. In carrying out this behest of the statute nearly all of our hospitals employ trained nurses as special field agents whose work in the domain of prevention and after-care is of inestimable value. These agents are trained social service workers, who devote their whole time to the interests of patients who have been discharged from the hospital, or are away on parole; they visit them in their homes throughout the hospital district, confer with them and with their friends as regards their welfare, advise them as to their habits, modes of exercise, recreation and occupation and frequently aid them in securing employment, or assist them in the selection of more suitable living quarters if they are maintaining themselves away from home. In this way, aided by the hospital physicians, with whom they keep in constant touch, our social service workers are often able to ward off relapses in paroled or discharged patients, and not infrequently actually prevent mental break-down in other members of the patient's family. The home care service should go still further in the prevention field and include the detail of hospital nurses in homes where potential patients may be cared for, through

[4] Annual Report of the Committee on Mental Hygiene of the State Charities Aid Association, 1916.

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a period of mental disturbance, by the family physician and restored to health without commitment to the hospital. I think this service should be provided without expense to the family and should be regarded as a profitable investment by the state, as it would undoubtedly lessen the number of commitments and correspondingly the burden the state must bear in caring for dependents of this class.

The new immigration law recently enacted by Congress and now in effect, although open to criticism from some economic viewpoints, will unquestionably be of great benefit to the country as a bar to the admission of mentally defective aliens. This law provides also for the deportation of such aliens if their infirmities are determined within five years after entry into the United States. Many of our institutions for the insane are now crowded with aliens of this class and the need of protection against this evil, never more urgent than at the present moment, will become more and more acute during the next few years on account of the increase in insanity that must result from the great war. The new law, therefore, with its provision for fines collectable from those who knowingly bring insane or mentally defective aliens into the United States, its provision for officers with special training in psychiatry at the large ports of entry, and the lengthening to five years of the period during which insane and other mentally defective aliens may be deported, cannot fail to be of immense practical value in keeping out of the country a class of persons wholly unfit for the duties of citizenship, unfit to become the parents of American children and who, if admitted, must necessarily become a burden upon the commonwealth and a menace to the race.

In reviewing the general field of psychiatry some of its critics—and they are not all outside the fold—have been prone to allege an absence of the progressive spirit in our institutions for the insane as compared with the general hospitals in the larger cities, and that "non-scientific" methods of studying insanity have prevailed. We are charged with being "too frequently satisfied if our patients are comfortably housed, our wards not too crowded, the routine of the day's work not interrupted by untoward incidents, and our statistical tables up to the general average as to the percentage of recoveries and possibly a little below as to the percentage of

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deaths." [8] Undoubtedly there are many institutions to which such criticism is still applicable, but in our well ordered hospitals for the insane to-day, the routine and stereotyped procedures of a generation ago, long since gave place to a study of the individual case in which thorough analysis of the mental symptoms and exhaustive laboratory research applied to the physical aspects, are the foundations of diagnosis and treatment.

The history of the remarkable progress of the medical sciences in the past decade or two has been largely written in the pathological, physiological, chemical and biological laboratories and psychiatry has by no means been a laggard in this great movement. We now better understand the pathology and etiology of many of the psychoses as a result of laboratory study and are therefore better able to prevent insanity and to cure our patients in whom mental disorder has developed, than ever before. It can no longer be said that "there is no pathology of insanity." To-day we have the large group of so-called organic psychoses, in which there are definite lesions of special organs or definite etiological factors to explain the mental symptoms, the recognition of which is the direct result of research in laboratories.

This large group includes traumatic psychoses, senile and presenile psychoses; psychoses with cerebral arteriosclerosis; dementia paralytica; psychoses with cerebral syphilis; psychoses with Huntington's chorea, with brain tumor or abscess, with cerebral embolus, with tubercular meningitis, central neuritis, multiple sclerosis, tabes dorsalis, acute chorea, etc.; the alcoholic psychoses; drug and other toxic psychoses; lead intoxications, gas poisoning and pellagra. Then there are the infective and exhaustive deliriums; the auto-toxic psychoses, such as the thyreogenous, uremic and diabetic disorders, and many others which might be added to the list. The laboratory work on syphilis alone has been of inestimable benefit to psychiatry. The Wassermann reaction introduced in 1906, has established beyond cavil the etiological significance of syphilitic infection in the causation of dementia paralytica, and the finding of the syphilitic organism in the brain and the cerebrospinal fluid of paretics may be said to have completed the chain of evidence that "without syphilis there is no

[8] Edward N. Brush, M. D., Presidential Address, New Orleans, 1916.

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paresis." This study is still being carried on and our knowledge of the various manifestations of cerebral syphilis is steadily advancing.

These studies are of great importance from a therapeutic viewpoint. The comparatively recent introduction of salvarsan into our therapeutic armamentarium, by Ehrlich, has added a stimulus to the study of the reaction of the central nervous system to syphilis, and it can be safely said that to-day there is much more hope for successful treatment in the cerebral syphilis reactions than ever before. The Wassermann reaction has demonstrated its value as an aid to diagnosis to such an extent that it is now regarded as necessary in the complete examination of any case admitted to the hospital; without it we cannot exclude syphilis as an etiological factor in any case. In every instance where a positive Wassermann reaction is found in the blood serum lumbar paracentesis should be performed and the cerebrospinal fluid examined by the Wassermann method. The number and character of the cell content, the bacterial and the globulin content of the fluid should also be determined.

Progress is being made in our laboratories in the study of the toxic-infectious-exhaustive disorders. The various bodily functions: nutrition, digestion, nervous energy, etc., are all manifestations of chemical processes; disturbances of metabolism result from external and internal infections and toxic substances and often result in intoxications, the importance of which, in nervous and mental diseases, is commonly admitted. It is well known that bacteria or their toxins may act directly on the brain, or they may cause metabolic disorders elsewhere in the body, which produce auto-intoxications. These infections and intoxications are now occupying many of our laboratory workers and through their activities we are every day controlling infections and toxins by vaccines and antitoxins, and the field of Ehrlich's side chain theory is constantly widening in its applications to the problems of psychiatry.

Besides these investigations in the purely scientific field, the entire scheme of hospital procedure, as it affects the patient, has undergone a radical change. Hydrotherapy and massage are recognized as exceedingly valuable therapeutic measures; industrial and diversional occupations; classes in physical culture and

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the systematic re-education of patients, especially of the dementia præcox type, together with greatly improved hygienic surroundings, are all factors in the general plan of treatment which to-day not only makes for the greater comfort of the patient, but largely increases his chances of recovery.

With these activities at the bedside, in the laboratory, in the class-room and elsewhere in the hospital and its environment, which make for the better understanding of the reactions that underlie mental disorders, I am in most hearty accord, but in these days "when much wild doctrine, especially as to mental therapeutics, is being offered the public,"[6] I cannot avoid a growing scepticism as to the value of certain new procedures that have come into prominence during the past few years, commonly referred to as the psychoanalytic movement, introduced into this country by Freud and Jung in 1909. The exponents of this movement are active in the dissemination of its propaganda. A journal devoted exclusively to its exploitation is now published; its articles are usually entertaining, but frequently clouded by what Dr. Dana calls "an extraordinary clutter of terms" many of them newly coined for this special circulation and the cases reported are often of such picturesque and dubious character, so indefinite and nebulous in their portrayal as to warrant their classification in the realm of fancy rather than fact, and to remove them from the domain of science to that of imaginative literature.

To the psychoanalyst the key to every mental state, normal or morbid, is sexuality. However pure, innocent and free from sexual coloring our ideas may appear to be this appearance is delusive, for they are in reality steeped and saturated with sexuality. This condition is not only traceable to early childhood, but the psychoanalyst is even able to invade the period of intra-uterine life and to find there the prototype of adult fears in the fright the unborn infant experienced while passing through the pelvis of its mother. Similarly the infant obeys an incestuous impulse when he kneads with his little hands his mother's breast and flings himself greedily on the nipple.

Much confusion in this new psychology seems to have resulted from dissensions "amongst the leaders themselves, so that there

[6] Jung, C. G., Psychology of the Unconscious, English translation, New York, 1916.

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now exist two schools," " referred to in the literature as the Vienna school and the Zurich school";[7] of these the Vienna following seems to be the larger in this country. Freud is usually credited with the parentage of the psychoanalytic movement, notwithstanding the earlier activities of Janet and Breuer, neither of whom seems to have been sufficiently impressed by his achievements to assert a claim to priority. In dilating upon his power to " translate dreams," Freud is so confident of his ability to correctly interpret their meaning that he has only pity for the benumbed intellect that cannot follow his alert reasoning and discern with equal certainty the meaning of their symbolism.

In this connection it is interesting to note Freud's attitude toward the unbeliever; he says: " I have acquired the habit of measuring the grasp of a psychological worker by his attitude to the problem of dream interpretation, and I have noticed with satisfaction that most of the opponents of psychoanalysis avoided this field altogether, or, if they ventured into it, they behaved most awkwardly."[8] Nothing seems to be more conspicuous in the attitude of the master psychoanalyst than his self-satisfied complacency.

Abroad, psychoanalysis does not appear to have established a secure footing. Freud himself states that " France has so far shown herself the least receptive toward this movement," and " in England interest has developed very slowly." The standing of psychoanalysis in Germany, says Freud, " can be described in no other way than to state that it is the cynosure of all scientific discussion and evokes from physicians as well as from the laity, opinions of decided rejection, which, so far, have not come to an end, but, on the contrary, are constantly renewed and strengthened." " No official seat of learning has, so far, admitted psychoanalysis." " Italy, after many promising starts, ceased to take further interest." " And Vienna," says Freud, " has done everything possible to deny her share in its origin. Nowhere else is the inimical indifference of the learned and cultured circles so clearly evident to the psychoanalyst." To Janet, " the assertion that the neuroses can be traced back to disturbances in the sexual life, could

[7] Jung, C. G., Psychology of the Unconscious, New York, 1916.

[8] History of the Psychoanalytic Movement, by Prof. Sigmund Freud, Vienna. Translated by A. A. Brill, New York, 1917.

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only have originated in a city like Vienna, in an atmosphere of sensuality and immorality not to be found in better cities, and it thus represents only a reflection, the theoretical projection, as it were, of these particular Viennese conditions."

Delage, of France, recently the recipient of a very high honor in England—the Darwin Medal—by the Royal Society, says of the psychoanalysts: "These men are the sincere and unhappy victims of a lamentable misapprehension; they have applied to the human individual the psychology of the inhabitants of the moon, such as some shrewd Cyrano on returning from a pretended voyage to our satellite might have imagined, in order to make it as different as possible from terrestrial realities."[9]

After somewhat extended reading of the psychoanalytic literature with a sincere desire to separate the wheat from the chaff, I am constrained to agree in considerable measure with Dr. Dercum, that it is a matter for profound regret "that at a time when psychiatry is beginning to unfold a practically limitless field for actual scientific research, men should be found willing to devote themselves to a cult, to an ism, which, like a salted mine, returns to the investigator only that which he himself puts in it." "How much more inspiring it would be to know that they were at work upon the biochemical problems confronting them to-day at every step, problems of auto-intoxication, of the toxicity of the sera and secretions, the doctrine of the leucomaines, the problems of metabolism in the heboid-paranoid group and in manic-depressive insanity and in epilepsy, the problems presented by the biochemistry of the blood, of the cerebrospinal fluid, the suggestive parellelism between auto-intoxication and recovery in the insane on the one hand, and Ehrlich's theory of infection and immunity on the other, and further, the whole world of serological problems now opening up, not to mention the ever widening rôle of the internal secretions."[10]

In conclusion, permit me to say that, notwithstanding the mild pessimism of some of our associates and a tendency on the part

[9] Psychoanalysis, A New Problem, by Dr. Yves Delage, Journal of Mental Science, London, January, 1917.

[10] Dercum, F. X., M. D., Transactions American Medico-Psychological Association, Vol. 21, p. 319.

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of others to stray from the beaten paths in search of " false gods,"

> " Like one who has been led astray
> In the heaven's wide, pathway,"

I regard the future of mental medicine as filled with golden promise. Serious, thoughtful students of psychiatry are busily at work on problems of vital importance, and I venture to predict that within the period of a decade or two their labors will result in a much better understanding of the etiology, pathology, diagnosis and treatment of mental diseases than we now possess. To that exalted end, even though we of the passing generation add no brilliant discoveries, yet may we each contribute our bit by faithfully doing the day's work in accordance with the light vouchsafed us. We shall then have " kept the faith "; we shall have " fought the good fight " on behalf of suffering humanity, and, perchance, when life's mellow autumn shall have arrived and we are ready to lay aside the burdens of professional life, we shall have earned the right to say, with the Grecian poet of old:

> " Now I close my work, which not the ire
> Of Jove, nor tooth of time, nor sword, nor fire
> Shall bring to naught. Come when it will that day
> Which o'er the body, not the mind, has sway,
> And snatch the remnant of my life away,
> My better part above the stars shall soar,
> And my renown endure forevermore."

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ANNUAL ADDRESS.

DEVELOPMENT OF THE PERSONALITY.

By PROF. EDWIN GRANT CONKLIN, Princeton University.

I submit that your president has cut out for me a very difficult task. Certain former friends of mine—I cannot in the present circumstances account them otherwise than that—induced me to appear on this occasion before a body of specialists, I, a person who works most of the time with general biology. I feel a great hesitation in attempting to speak in this presence and especially now after your president has said so many kind things in his introductory address. Furthermore, I labor under an additional difficulty which I must mention before I go further; and that is that I had hoped to appeal to two of your senses to-night, your vision as well as your hearing. But owing to the inability of the hotel management to procure a stereopticon on this holiday, it is necessary for me to leave out the lantern slides; hence, I must appeal only to your sense of hearing. I hope to make plain, however, some rather complex subjects which are difficult to present through the hearing alone.

No intelligent person doubts that man is an animal, a vertebrate, a mammal, although there are some people who hesitate to accept that classification. The late John Fiske used to tell of a man who became very indignant when told that he was a mammal and replied, "I am not a mammal nor the son of a mammal"; he explained that he had probably been brought up on a bottle. No well informed person doubts that heredity, development and evolution apply to man as well as to all other living things, and yet I have known people who granted only grudgingly that man develops from a fertilized egg or that heredity has any part in the development of mind or soul, while they rejected altogether the conclusion that evolution applies to man. Such persons are influenced by sentiment rather than by evidence and it is useless to attempt to convince them by an appeal to facts, while those trained in science do not need to be convinced of those elemental truths.

"Development," said Karl Ernst von Baer, "is a veritable torchbearer in the study of organic bodies." This is true of the study of the entire personality of man, of the mind as well as of the body,

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for as the body of man develops out of the structures of the fertilized egg, so the mind of man develops out of the functions of the egg.

In the development of personality as in the development of any organic structure there is no creation *de novo,* but merely a transformation of parts and functions already present in the germ. New things appear in the course of development by a process of *creative synthesis,* for just as hydrogen and oxygen when they combine form water which was not present in either of its elements, so the germinal functions of sensitivity, tropisms, organic memory, trial and error, persistence of organization, etc., when all cooperate, produce by a process of creative synthesis something which was not present before, viz., *consciousness.*

The factors or causes of development, whether of the body or of the mind, are found both in the germ cells and in surrounding conditions, or, in other words, in heredity and in environment. Heredity is on the whole a more important factor than environment; it determines all the possibilities of development and all its main results, whereas environment serves chiefly to modify these results.

One of the greatest discoveries ever made in biology is that of Gregor Mendel, that the characters of an organism which are derived from the father and those from the mother separate in reproduction, the germinal causes of these characters going into separate germ cells, so that one germ cell will carry the inheritance units or germs for certain paternal characters and another for corresponding maternal characters, and when male and female germ cells from different individuals unite in fertilization a new combination of characters results, thus giving rise to a new individual.

It was by intensive observational and experimental work that this great discovery was made; the mere accumulation of a vast body of cases illustrating the resemblances between parents and offspring, such as the big volumes of Prosper Lucas on heredity, could never have led to the discovery of Mendel's law; and I think it is especially worth while for physicians and others engaged in studying human heredity to remember that the thorough study of a few families is worth more than the accumulation of statistics regarding thousands of illustrative cases.

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The principles of Mendel make it possible to analyze an individual into many characters which are hereditarily separable and to follow these separate or unit characters through many generations. Some characters, such as blue or brown eyes, straight or curly hair, etc., are simple and it is relatively easy to determine the precise manner in which they are inherited; other characters such as skin color, size or stature, etc., are more complex and it is more difficult to determine their method of inheritance, and in general the more complex a character is the more difficult it is to determine its mode of inheritance. Nevertheless, whenever a complex character can be analyzed into its simple constituents the latter are always found to be inherited in Mendelian fashion.

But while the mode of *transmission* of the inheritance factors or genes for unit characters is a relatively simple matter, the *development* of even the simplest character is inconceivably complex, depending upon the interaction of very many germinal and environmental causes. For example, it is known that the differences in structures, functions and instincts between queen bees and worker bees are due to the character of the food given to the larvæ. In the case of man and other higher animals the presence of internal secretions from the thyroid, thymus, pituitary body, sex glands, etc., exercises a profound influence on the development both of the body and of the mind. All such influences are, strictly speaking, environmental, since they are not due to the constitution of the germ cells, but to conditions outside of these cells.

In man, training, education and social conditions also exercise a profound influence on the development of mind and personality. Indeed, heredity determines merely the possible limits of development, while environment and education determine the actual results which will be realized within these limits.

Recent studies have shown that the development of such simple characters as coat color (Wright), eye color (Morgan) and sex (Wilson, Lillie, Goldsmidt), are exceedingly complex and that very many hereditary factors may be involved in the process. When we come to the development of more complex things such as temperament, feeble-mindedness, insanity, personality, we are dealing with the most complex phenomena in all the world—inconceivably more complex than any of the problems of astronomy, physics or chemistry. If eye color in the fruit fly is dependent

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upon a large number of inheritance factors, as Morgan and his pupils have shown to be the case, how much more probable is it that epilepsy, feeble-mindedness, genius and insanity are dependent upon a still larger number of inheritance factors, as well as upon an innumerable number of environmental causes. We may be sure that when the whole "alphabet of degeneracy from alcoholism to wanderlust" is attributed to the lack of a single hereditary factor, there has been a pitiful failure to recognize the complexity of the phenomena in question.

Particularly in the study of the development of mental and moral traits there is great need of caution against over-simplification. The web of hereditary, environmental and educational causes is so intricate that it is often impossible to decide whether a given trait is inherited or not, and it is usually impossible to predict what the character of offspring will be. Some very unpromising stocks, some most untoward environments, have produced wonderful results. When we remember that Beethoven's mother was a consumptive and his father a confirmed drunkard; that Michael Faraday, perhaps the greatest scientific discoverer of any age, was born over a stable, that his father was a poor, sick blacksmith, and that the only early education he had was obtained in selling newspapers on the streets of London and later in working as apprentice to a bookbinder; that Lincoln's father was a ne'er-do-well, and his early surroundings and education most unpromising; that George W. Child was a nameless foundling, and so on through the long list of names in which democracy glories—when we remember these world-famous men and when we reflect that eugenicists and birth-controllers would have deprived the world of these superlative geniuses if they could have had their way, we may well inquire whether it is not fortunate that we are in the hands of an all-wise Providence rather than of an unwise propaganda.

This is not to say that these and other geniuses have not developed according to definite laws. It is no miracle that Lincoln should have

> "Burst his birth's invidious bar,
> * * * * * *
> And mounting up from high to higher,
> Become on fortune's crowning slope
> The pillar of a people's hope,
> The center of a world's desire."

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But the processes by which genius is produced are extremely complex and at present we are just beginning to learn about them. Undoubtedly the factors or causes of all kinds of development are found in heredity and environment, but with regard to the development of the most complex thing in all the world, viz., human personality, we are as children in the morning of time.

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A WIDER FIELD OF ACTIVITY FOR THE ASSOCIATION.

By JAMES V. MAY, M. D.,
Superintendent, Grafton State Hospital, North Grafton, Mass.

The American Medico-Psychological Association has a dignified history of nearly 75 years of continuous activities. Founded in 1844, it has consistently maintained standards which have made it one of the most prominent of the medical organizations of the country. It was conducted for nearly 50 years as the official organization of the superintendents of the American institutions for the insane, and only adopted its present designation after the reorganization in 1892, when its membership became more general.

It now includes as active members physicians "especially interested in the treatment of insanity," or who "by their professional work or public writings, have shown a special interest in the care and welfare of the insane." Laymen who "have distinguished themselves by their attainments in branches of science connected with insanity, or who have rendered signal service in philanthropic efforts to promote the interests of the insane" are eligible to honorary membership. The Association has assumed a position of prominence among the scientific organizations of the country, and includes in its membership practically all of the prominent American psychiatrists of the day.

It has, however, unnecessarily and unwisely relinquished its official representation of the various state bodies responsible for the management of the institutions, public and private, for the insane. In so doing, it has failed to take advantage of the opportunity of encouraging and assisting in the maintenance of high standards of care throughout the country, of influencing legislation conducive to the welfare of the insane, and of guiding the destinies of the institutions as it should.

The Association should be the most powerful factor in the country in obtaining state recognition of the needs of the insane,

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in fostering legislation which will prevent political interference with the hospitals, and in bringing the standards of care up to the high plane represented by ideals kept constantly before the public by this organization since its foundation in 1844. If this is to be done we must include in our membership the men who control the policies of the institutions in the various states.

For this purpose I would suggest for your consideration, if necessary, an amendment to the constitution which would render eligible, ex officio, as active members all duly elected or appointed managers or trustees of state hospitals for the insane, and all members of commissions and boards of control having administrative or financial responsibility for state institutions for the insane, such eligibility to continue while actually in office. They should, of course, be required to pay annual dues and be subject to all the requirements of the constitution applying to active members. If the Association is not to be an official organization representing the institutions for the insane—and it has not been since 1892, it should at least include in its membership the managing and governing bodies vested with the administrative control of the hospitals in the various states and provinces. This subject might very properly be referred for further consideration to a committee to be appointed by the president.

The Association should, in my opinion, be something more than a purely scientific body, meeting annually for the presentation and discussion of papers relating to psychiatry. It should officially exercise the functions which the professional qualifications and official position of its active members would fully warrant. No other one thing would go so far towards insuring humane and proper care of the insane in this country.

The report of the Committee on Statistics at this session calls attention to another phase of activity of the Association which has been under consideration for many years. At the 23d annual meeting in 1869. Dr. Nichols called the attention of the Association to a system of statistics adopted at the International Congress of Alienists held in Paris in 1867. A series of statistical tables, 21 in number, were prepared by a committee and used unofficially for several years, although for some reason never formally adopted. Another committee reported on this same subject in 1896, unfortunately without any definite action.

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At the present time we are without any statistics on the insane of the country which can be correlated and made a subject of scientific study and investigation. With a wealth of material available which would go far towards solving many important problems relating to psychiatry, we find the various states, and more often individual institutions in the same state, working along entirely dissimilar lines.

Our text books are filled with uncorroborated assertions relative to the frequency of certain forms of insanity. These are often based on the personal experience of the author or on statistical data available from his own hospital. The official publications of a few isolated states give such information in an intelligent form, but anyone who wishes to compare conditions existing in one community with those in another, or make comparative studies of large numbers of cases, almost invariably finds the necessary information unavailable.

Accurate statistical data showing the etiology of insanity is published in but few places, and the discussions of this subject are based more on opinion than on the study of a sufficient number of cases to warrant any conclusions. The same absence of authentic information renders it impossible to obtain any accurate knowledge regarding the recovery rate of the different psychoses. Dementia præcox is conspicuously absent from many of the hospital reports, which include primary dementia, chronic delusional insanity, terminal dementia and other conditions which may or may not belong in the dementia præcox group.

When statistical reports are made they usually contain information, which is of itself very largely useless, relating to the civil condition, color, sex, age, residence by counties, financial status, etc. Unless the psychoses are shown in these tables they are of no value whatever. In any event it is impossible at the present time to obtain statistics regarding any one phase of insanity which is of any importance, from more than a very few states where the insane population is unusually large.

Accurate statistical reports made along uniform lines would enable us to reach important conclusions regarding the frequency of occurrence of the various psychoses, the probability of recovery, the intercurrent affections causing death, etc.

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A uniform basis for financial reports made annually to the Association would be of incalculable benefit. This would not conflict in any way with returns made to local fiscal officers. Our attention is often called to the apparent fact that the per capita cost of maintaining the insane in certain states is unreasonably high, whereas they are cared for at a much lower rate in other communities. This has frequently been made the subject of legislative investigation, usually with highly misleading conclusions, owing to the fact that we have no uniform way of computing costs. Some institutions in reporting the cost of maintenance deduct from the gross expenditures the receipts from all sources, including the care of reimbursing patients and the value of all farm and manufactured products. Others very properly do not. Some include only the ordinary repairs and replacements and others the cost of new and additional equipment, extraordinary repairs and even additions to buildings. The result is that, if the statements published in annual reports are taken at their face value, the same methods of administration that would appear penurious in one institution would be interpreted as gross and almost criminal extravagance in another.

The reports of the State Hospital Commission in New York have been enlightening as to the burden of maintaining aliens in our public institutions. It has been shown that there are now about nine thousand patients in the hospitals of that state who are not residents of New York or citizens of the country. The actual maintenance of these aliens is costing the state approximately two million dollars per year. This is undoubtedly a condition which exists in practically the same relative proportions in the other states. The facts which are necessary for an intelligent discussion of this important question are, however, lacking because this subject has not been generally included in statistical reports.

The national and various state mental hygiene societies have been endeavoring to educate the public regarding the importance of the relation existing between insanity, syphilis and alcohol. Unfortunately statistics on these subjects cannot be obtained in many of our larger communities.

In view of the objects and purposes of the American Medico-Psychological Association it would appear to be the obvious duty of this organization to endeavor to remedy this unsatisfactory con-

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dition of affairs. The report of your Committee on Statistics has pointed out the way in which this can be accomplished. The approval by the Association of a scheme of uniform statistical reports of the insane will unquestionably insure the success of such a movement, and a concerted effort on the part of our members is quite sufficient to bring about the adoption of these statistical forms in the various states and insure their general use.

I would strongly urge upon the Association the advisability of establishing a bureau of statistics for the purpose of compiling and publishing annual reports on the insane in all the states and provinces as far as obtainable. Such a bureau could probably be maintained at a comparatively small expense in cooperation with the National Committee for Mental Hygiene.

The success of "The Institutional Care of the Insane in the United States and Canada" shows conclusively that undertakings of this magnitude are entirely practicable, if the Association will assume the function which properly devolves upon it of correlating the work done by the various states. It would appear to be practically certain that the federal authorities can be induced to arrange for a census of the insane based on our official classification which will, for the first time, furnish us with intelligent information on this important subject. If the Association accomplishes nothing else, this would constitute one of its most important contributions to medical progress.

DISCUSSION.

DR. STEDMAN.—Mr. President, I think this is a most important matter and I heartily endorse Dr. May's scheme for a better plan of statistics. One result of the lack of uniform national statistical tables I have not seen mentioned; and that is the vitiation of our national census statistics with regard to the insane and feeble-minded. That department of the National Census has been, to be sure, more elaborate of late and the data much more carefully compiled; but on the vexed question as to the increase of insanity, its statistics are practically valueless for want of statistics relating to first admissions—the admissions of *first cases*—to our hospitals. It stands to reason that statistics which do not give the number of *fresh* cases admitted to the hospital in a given period in proportion to the increase in the population, but enumerate simply all the admissions, including therein all the readmitted cases and other chronic cases, must necessarily be practically worthless; and for want of proper tables we have to turn to those of Great Britain which are very good and useful. We have nothing of the

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sort in this country. I think it most important that the statistical report presented by the special committee on the subject should be accepted and that it should be adopted and utilized in all the hospital reports of the country.

DR. WHITE.—Mr. President, I may not have correctly understood one matter: I take it that this paper of Dr. May's is more or less in the way of, or in the nature of a report of the Committee on Statistics.

THE PRESIDENT.—The statistical report is a very elaborate report. Dr. May's paper is quite a different matter, although it is closely related to the general subject of statistics.

DR. WHITE.—Mr. President, I was merely going to suggest that perhaps it would effect the object that Dr. May and the committee is trying to accomplish if the Association should accept the report of the committee when it is duly made and cause it to be printed with the suggestion on the part of the Association that the outlines suggested be adopted by the various states. It has been prepared by very competent men. Great Britain has succeeded in getting uniform statistics by getting all the hospitals in that country to do this and I believe that we too might accomplish it in this way.

DR. GERSHOM H. HILL.—Mr. President, touching on the first recommendation of Dr. May as to having official boards or members of official boards become members of this Association, I would call your attention to the National Conference of Charities and Corrections which holds its annual meeting in Pittsburgh soon. I have attended several meetings of the conference and expect to attend the one this year. We find that it is a great help to public officials to attend these conferences and to participate in them actively. I think the more they attend them the more useful they become to their institutions. I think that there should be everywhere a desire on the part of all state institution heads to inform themselves concerning this kind of work.

DR. ROBERTSON.—Mr. President, I enjoyed hearing Dr. May's paper very much and I think he should have support so far as his plea for reform in the nomenclature of statistics is concerned. I hope I will not be considered old-fashioned if I differ slightly with the Doctor as to his plan of bringing managers and lay members in as members of this body. It seems to me that the success of this Association has resulted largely from its personnel. The experience of our members has caused them to form opinions and the result has been a growing and a harmonious body. If we bring in laymen and boards of managers or others connected with affairs relating to the care of the insane, we would bring in inharmonious elements and as an old-timer I feel that I cannot approve of the Doctor's suggestion. I think it is the duty of the superintendents of the various institutions to educate their boards; to bring them up to a point where they become able to do efficient work for the institutions. I found always that it was the duty of the superintendent to manage his board. Some succeed in this and some

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become discouraged and retire and others die in the harness. I would dislike to see this work taken from the superintendent's shoulders because I think it is of very great value to his board.

DR. COPP.—Mr. President, there are a great many forces at work along these general lines and I think this subject brings up the question whether they can be correlated along more definite courses of action. It would be entirely in harmony with what is being done in most progressive states. Annually or semiannually the trustees of institutions and their superintendents come together in a conference. I think this has been a growing movement and productive of very great good. If this Association should broaden its membership it would be entirely in harmony with this movement. This Association would then represent, as a national association, all the forces interested in this great problem.

DR. BLUMER.—Mr. President, I was not in the room when Dr. May read the first part of his paper so that what he said as to the admission of boards of managers and trustees to membership in this body is largely a matter of inference.

I also wish, as another old member, to enter my protest against any scheme that would tend further to laicize the American Medico-Psychological Association. I am old enough to remember how most of us were pleased when the title of our Association was changed from that of The Association of Medical Superintendents of American Institutions for the Insane to that of the American Medico-Psychological Association. I remember, too, the further step forward in 1903 when we became a component member of the American Congress of Physicians and Surgeons. I remember also—and remember, I must say, to my own shame—that as a step backward and downward we soon withdrew from the Congress. The aim has been for several years to make this Association a more scientific body, and to laicize it now, in the manner proposed, would be a further step downward and backward. I am very glad to note that at least one member has made his views known on this subject and I hope there are others of like opinion who will express themselves on this floor.

DR. WORK.—Mr. President, I would like to say a few words to express my appreciation of what the member who first spoke said and also of the views just expressed by Dr. Blumer. I have served under a Board of Control, I am a member of one now, I have never suffered from them in any way and I have never tried to harm any one that I can recall, but I am frank enough to say that the greatest detriment or injury to state institutions in their scientific work are their boards of control. These men are usually appointed, as we know, for political reasons; and there are many superintendents of state institutions who are compelled to keep one eye shut and the other on the Board of Control during their whole life as superintendent. These boards are a menace to state institutions as now selected, although there are exceptions. Many members of these boards are appointed and take their office with no conception of institution work but seem to feel that they are there because the medical man in charge is

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not supposed to have any conception of business methods. Their primary instinct is to lower the cost of maintenance; and I personally feel that to admit those men to membership in this Association in any capacity except as visitors would be a grave mistake and would lower the tone of the Association which we are trying to build up and broaden out as a scientific body.

Dr. Carlos MacDonald.—Mr. President, I heartily concur in the remarks of Doctors Robertson, Blumer and Work in regard to the question of the admission of laymen into active membership in this Association. The Association has now a standing and reputation as a scientific body, and if we admit a lot of laymen, members of boards of managers, or of boards of control, the Association would soon becme a charitable rather than a scientific body. I know from observation and experience something about boards of managers, and I have sometimes felt that I would like to write a paper on "What I Know about Boards of Managers." I am heartily opposed to changing the essential character of this body through the introduction of lay members. I commend the meetings to which Dr. Copp has referred to the various states—the conferences of medical and other officers of institutions for the insane—I know that such meetings are most beneficial in the state of New York where they are of frequent occurrence, but they are held for the purpose of considering administrative questions, methods of management, expenditure, etc., and the lay members are not there to consider questions of psychiatry. That, I think, is alone the function of this Association. Moreover, as Dr. Work has suggested, some managers are inclined to indulge in cheese-paring in matters that fall within the medical purview; and some of them feel that the medical officers are lacking in business capacity, notwithstanding the fact that the superintendents of the hospitals (I am speaking for those of the state of New York) are, as a rule, excellent administrative and executive officers. I know from personal experience some managers whose chief aim in the institutions with which they are connected is to see how cheaply the care of the insane can be made—that is, for how little body and soul can be kept together; they want to make a record on the financial side and frequently politics come into the administration of these boards—I do not mean all, but instances of that kind are not wholly unknown in the state of New York. Although I must say that there has been a marked improvement in the quality of the men appointed on these boards in recent years, men who command the highest respect in their respective communities. Another comparatively recent and highly commendable innovation is the appointment of women on such boards.

Dr. William A. Jones.—Mr. President, many years ago I served as assistant physician in a hospital for the insane in Minnesota and, after four years' service, I dropped out because of the political status of the Board of Trustees. I afterward regained some prestige by becoming a trustee myself, which position I held for two or three years, until a new administration came in and then I was promptly dropped out.

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I feel that conditions have improved very much in Minnesota in the abolishment of the uncertain board of trustees. We have had, for some years now, what Dr. May has suggested—a conference board made up of superintendents and assistant superintendents of various state hospitals, together with the Board of Control, and I know that this makes a very satisfactory conference body. They have monthly meetings and talk over various hospital problems and usually one of the superintendents or members of the Board of Control reads a paper.

These conferences have done much for the institutions and for the Board of Control in that they leave the superintendents free to attend to the medical work and the Board of Control has become educated in the hospital management so they confine their activities largely to construction and to the disbursement of appropriations from the legislature. The service is better on all sides and the education of the community at large, and throughout the state has gained in influence.

I believe that the introduction of these semi-politicians would be a great detriment to the Medico-Psychological Association.

DR. CARMICHAEL.—Mr. President, I certainly believe that some method of determining a more uniform system of statistics is the prime need of our institutions throughout the country. At the present time the classification in every institution seems to follow the predilections of its presiding officer or of the member of the staff having in charge the clinical workings of the institution; thus, the classification is based entirely upon their conception, and it is safe to assert that that is determined by their favorite medical author. I recall an institution that for a period of 12 years showed exactly two classifications in recording the types of insane admitted; 80 per cent were classed as cases of mania and 20 per cent melancholia. Now, there were 12 years of statistical data that were absolutely without value to the profession. The important question now is in what particular way can we get at this matter of classification to provide a uniform standard that will serve not only for our own country, but will be an international classification. That is a point I would like to hear fully discussed.

It is of the utmost importance both from a standpoint of statistical value as well as from the standpoint of universal nomenclature effecting the value of physicians in institutional work that a classification uniform in its application be adopted at the earliest possible time.

DR. C. B. BURR.—It seems to me, Mr. President, that if this proposed classification is to be adopted action had better be taken before the membership is very much augmented. Certainly there are heads enough now to get together and these medical heads entirely competent to undertake work of this kind. We don't need lay membership to put it across. I should feel very reluctant, indeed, to see the membership of the Association increased as Dr. May has suggested. Furthermore, I think you will all have to undertake in connection with this report, if adopted, a campaign of education. Representatives understanding it will have to go from institution to institu-

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tion and enlighten some of the less enlightened as to what the classification all means and as to what is to be done with it.

THE PRESIDENT.—If there is no further discussion of Dr. May's paper, I will ask him to say a few words in closing.

DR. MAY.—Mr. President, I am very glad to find that at least I have injected some interest into the proceedings at this time and brought up a subject which seems to have been one of considerable importance.

I agree with the suggestions that have been made by several of our members about boards of control and managers of institutions in a general way and I think the speakers have proved conclusively that these boards need the refining influences of this Association to guide them properly. I still feel, however, that if we had them associated with us, we would be in a position in which we might influence legislation and remedy such conditions as Dr. Jones has adequately and eloquently described.

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THE INFLUENCE OF WARS ON THE PSYCHOLOGY OF THE TIMES.

By CHARLES K. MILLS, M. D., LL. D.,
Emeritus Professor of Neurology in the University of Pennsylvania; Neurologist to the Philadelphia General Hospital.

Axiom of Thucydides that War Educates through Violence.

Although not entirely applicable as a text for all that follows, I might introduce my subject by a citation from a recent essay in *The Fortnightly Review* for March, 1917, by Edmund Gosse on "Lord Cromer as a Man of Letters." "In connection with the axiom of Thucydides that war educates through violence, he (Lord Cromer) wrote, 'The Germans, who, in spite of their culture, preserve a strain of barbarism in their characters, are the modern representatives of this view. There is just this amount of truth in it—that at the cost of undue and appalling sacrifices, war brings out certain fine qualities in individuals and sometimes in nations.'"

The Spirit of the People in Peace and in War.

In the piping times of peace, nations sometimes become not only unheroic but sordid. They worship Mammon, pursue pleasure, become snobbish and invest themselves with imaginary virtues. A tendency to degeneration, which fortunately is usually only temporary, is one of the results. War comes with its excitements, its hopes and its fears. If it is a war in which the nation's life is at stake it appeals to the often latent, but always existent, patriotism and brings out the heroic qualities of the people. Gosse's comment on the words of Lord Cromer is that this may surely be taken as a direct prophecy of the magnificent efforts of France in the present conflict.

For many years before the outbreak of this war it was by no means a rare observation by unthinking commentators that France was becoming a decadent nation. At an address by a distinguished

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educator at one of the colleges near Philadelphia the speaker voiced this too widely held opinion. A French member of the faculty who was one of a large audience rose in his seat and remarking in a dignified but emphatic way, "This is not true," left the hall. No one will I think deny the truth of this indignant comment in the light of what France has done in the last three years.

Psychological Predisponents and Excitants.

To grasp the effects of war and revolution, which usually means war, on the psychology of the times, one must look backward to discern the causes which have activated the people in periods antedating war and revolution. It is only in this way that we can really obtain clear ideas as to the effects of war.

One objection which may be made to this paper as a contribution to the meeting of a medical association is that it is not psychiatric, but psychological. This objection, however, does not seem to have much strength. The psychology which leads to war and which is excited or intensified by war is in truth often a morbid psychology and if not morbid in the usual sense of the psychiatrist, it is one whose study may be illuminating for him.

Our subject can be perhaps best discussed with advantage under those old fashioned medical headings of "predisposing and exciting causes." The predisponents to war in a proper sense often in large part are the predisponents of the psychology which develops in a time of war. One war often predestines succeeding conflicts.

Gustave Le Bon has emphasized the importance of affective and mystic agencies in the psychology of war and especially of revolution, believing that such causes are far more influential than the intellectual processes. He combats the view that revolutions which usually mean periods of violence as well as of change, are the outcome of rational activation. Voltaire, Rousseau, the encyclopedists and others, who were educating the people in new ways of thinking about governments and society, had according to him much less to do with precipitating revolutions and the wars which accompany or follow them than affective or mystic causes. There is much truth in this view of Le Bon, but he probably gives too little weight to the progressive inculcation of new ideas.

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The Determining Psychology of Successive Wars.

Great wars, and some of minor importance, can usually be traced to the influence exerted by previous wars on the material prosperity and the psychology of the participants. This of course is a fact more or less generally recognized, but the psychological effect is not always properly apportioned. One country may be devastated and overwhelmed, while the other emerges enlarged and enriched, but it is neither the material loss on the one hand, nor the gain on the other which plays the most important rôle in the initiation of new conflicts. War leaves the people engaged in it a psychological inheritance which is potent for future peace or war. This psychological inheritance is largely affective and therefore illustrative of the views of Le Bon. The emotions and sentiments of the people at one period of conflict become more or less crystallized in their psychology and later under the influence of a variety of solvents are set free, again to become active.

Historical Illustrations of Transmitted Psychology.

Going back to the times of the English Commonwealth (1649-1653), the spirit which was born of the struggle of the people against the tyranny of the king not only persisted in Great Britain, but was carried after the Restoration across the ocean—then a far wider span than at present. This spirit grew apace in the land, distinctly removed from the immediate control of those who would have checked its progress. It had its next exposition on the American continent in the French and Indian War (1756-1763) which, although in large part conducted on both sides by the military forces of two monarchies, was maintained and carried forward by the spirit of democracy which had its birth in the days of the Commonwealth. This war was in fact the struggle of a people reaching out for greater liberty and in so doing, striking at the dominant autocracy of Europe—that of France. The same spirit was handed on to the American Revolution, and somewhat more remotely but none the less certainly, to the great French Revolution.

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The Psychology of the Napoleonic Period.

No page of history is more fascinating than that which deals with the Napoleonic era. When the great revolution had its first culmination in the "whiff of grape-shot," which rendered futile the last defiant effort of Robespierre, France through the turmoil and terror of the revolution had reached a new psychology, one which permeated its people with a desire for a strong hand at the helm. It was this impulse and desire born of strife and suffering which brought the psychological moment making for the advent of a Napoleon.

Who that has followed the story of the illustrious Corsican has not appreciated the determining importance of the psychology of its changing episodes? From his two great Italian campaigns; from the 18th Brumaire to the field of Jena; from Jena to the Russian Débacle; from Berresina to Leipzig; from Leipzig to Elba, and from Elba to Waterloo and St. Helena, it was the changing psychology of France and her antagonists which created and continued the long conflict in which villainy and valor played such conspicuous rôles.

Out of the French Revolution and the Napoleonic period was developed the psychology which in part led to the recent Russian Revolution and the Prussian wars against Denmark, Austria, and France; which resulted in the creation of imperial Germany and assured new wars for its preservation and expansion.

Russian Psychology and the Russian Revolution.

Since the Russian upheaval in March, 1916, many have expressed the opinion that the revolution was the immediate consequence of the war. It was assumed in accordance with the axiom of Thucydides that the war had transformed a quiet and unthinking people into a nation of revolutionaries. Nothing could be further from the truth. To those who have brought about the change in the political policy of Russia the war simply was an opportunity to make use of forces already prepared. If the war had not come in 1914, the revolution in Russia could not have been long postponed. Realizing that the attack of Germany, if successful, threatened to destroy for a generation at least the hopes of those who were longing to place Russia in the list of the world's

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democracies, the people sprang to arms, not so much in defence of their dynasty, as of their aspirations.

The revolutionary propaganda in Russia is not of recent birth. Its dawn might easily be traced back several centuries, but it had its first great stimulus, as I have intimated, in the Napoleonic era. The remarkable Russian defence which brought about the French débacle in 1812, not only saved Russia from subjugation, but revealed to her people their own strength. If they could strike so successfully at a foreign foe, why might they not some day strike with equal success at the tyranny which was throttling them at home? This ferment worked steadily and slowly for democracy, but the greatest impetus to the revolution came with the abolition of serfdom by Alexander II in 1861. The revolutionary program has been developing by slow but sure steps during the last 50 years.

" Marshalled and concentrated before hostilities broke out," says Dr. E. J. Dillon, " the revolutionary forces were even then deemed potent enough to uproot the social and political system, lock, stock, and barrel, and the signal for releasing them was about to be given when the Kaiser's antics drew them off to the field of battle."

To revert to my homely medical method of presentation, the predisposing psychology of both the revolution and the war had been evolving in Russia through many decades, and the war with its torments and terrors, its hopes and its fears, its triumphs and defeats, simply brought to a head the long fermenting psychology. The " education through violence " of Thucydides precipitated the revolution in which with little bloodshed one hundred and seventy millions of people overthrew in a day a dynasty supposed to be invincible.

Will the revolution triumph or will it result in a state of chaos which will bring about a successful reaction? The psychology which made it possible represented a long developing condition which cannot end in defeat. Many fear that the outcome of the revolution will be a separate peace which will tend to the undoing of both Russia and her allies, but the forces at work cannot be turned to the benefit of a dynasty more antagonistic to liberty than that of the Romanoffs. A psychology has been created which can only be satisfied by the success of democracy.

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The Psychology of Germany.

Recently drawn into the great war which Germany and her allies are waging against the civilized world, it is difficult for an American to approach in an entirely unprejudiced spirit a discussion necessarily involving some consideration of the merits and defects of German character. Nevertheless, I think that this can be done. Like many of my fellow countrymen I have long held in admiration the brilliant scholarship and record in literature and science of Germany. German idealism at one time bade fair to lead the world. Even amid the heat and hatred inspired by a too vivid knowledge of the events of a war, the most far-reaching and frightful the world has ever known—a war for whose incitement and initiation many of us hold Germany responsible—we cannot lose sight of the great Germany of the past, the Germany of Lessing, Goethe, Schiller, Heine, of Humboldt and Helmholtz, of Beethoven and Wagner, of Virchow, Hitzig, and Ehrlich. However this war may terminate, the fate of Germany will not be that of Carthage.

The Thirty Years' War, the Seven Years' War, and the Napoleonic wars exerted upon Germany, as upon the rest of the world, an influence largely for the good of that nation. The present German spirit nevertheless has its main roots and development in Germany's conflict with the Danes in 1864; with Austria, her present ally, in 1866; and with France in 1870-71. These wars, potent in their influence on German character, were not in themselves great struggles for mastery. In this respect they did not rank with those of Frederick the Great, of Napoleon, or our own Civil War. The ease and completeness with which Germany overwhelmed her weak, though valiant, antagonists bred a spirit which has tended to her undoing. From the time of the Franco-Prussian War down to the beginning of the present colossal conflict the German mind has ingested and absorbed a pabulum which could not have any other outcome than the development of a self-confidence approaching self-idolatry. So it happened when Germany declared war on Russia and France and her legions swarmed through Belgium, they marched exultant in what to them was the sure hope of speedy victory. Throughout the first half of the war and to a considerable extent down to the present time this spirit has known no taming.

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As the flood-tide of German success begins to ebb we see a new psychological spirit, a new mental attitude. Through the nearly barred door of the most stringent censorship the world has ever known we begin to hear the story of this change. One of its most significant evidences is the recent announcement of Maximilian Harden who tells the German people that after all the enemies of Germany are unconquered and probably unconquerable. Other evidences are to be seen in the Socialist protests in the Reichstag. This is the sort of psychological change which sooner or later is developed in a nation which meets with positive or relative defeat. The contagion of the Russian revolution may also soon play its highly important psychological rôle.

The Psychology of England.

Quite as interesting an object of study as the German mind is the mental attitude of England. England even more than Germany has a noble literature, a splendid record in science, and a history of empire building unsurpassed in previous imperial records, different and unique when compared with the empire building of Rome and Spain.

England, unlike Germany, did not with swift rapid strides reach her present high place. The British empire, not all made by conquest, but by gradual expansion through conflict, exploration and peaceful accretion, has become the greatest of modern empires. Increase of power has gone hand in hand with the accumulation of wealth.

The success of England, although more gradual than that of Germany and based on more far-reaching causes, has had in it some seeds of evil. Protected by the conglomerate character of the nation, by the more versatile spirit of its people, and by its inheritance of constitutional freedom, England had not fallen into the slough of a fixed and narrow idea like militarism, although memories of Trafalgar and Waterloo had never ceased to influence the British mind. Too much prosperity and too much power however had caused her to lose sight of the high ideals often emphasized in episodes of her history. She had grown self-complacent rather than self-idolatrous. Absorbed by commercial enterprise and pursuit of peaceful pleasures at home and abroad she closed her eyes to the dangers which were threatening and sank

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into a cynical and unwholesome disregard of the most elementary principles of national defence. She failed to see her own weakness.

In this way through years of peace, punctuated by small successful wars, a psychology was developed among her people which left her in danger of destruction by some more self-centered and aggressive power.

Many brochures and books have been written during the progress of the present war. Some of these are interesting for the light which they throw on the details of the conflict; some for their insight into the psychology of belligerents and neutrals. Books of the latter class are comparatively few and not of great value, but in Wells's "Mr. Britling Sees It Through," we have at least a glimpse of the muddled and puzzled mind of the average Briton when the great storm broke on the world and aroused to a consciousness that he could no longer live secure and unchallenged with his household gods and his parish ideas.

The war came to the Briton with a message almost exactly the opposite of that brought to the German. As I have already said, to the latter it simply intensified a spirit which had been growing within him for more than half a century, a spirit whose vices were many, but whose greatest virtue was its singleness of purpose. To the Briton the war came as an awakening; nor was he easily aroused. The terrible experiences of the war have bred in him a better psychology.

The Psychology of America.

The psychology of America during the present war is of equal interest with that of Germany and England, although its cause and its continuation are more like that of the latter. Since the close of the Civil War, with the exception of the comparatively unimportant wars with Spain and in the Philippines, America has been at peace. In material prosperity she has advanced by bounds, but with this prosperity has not come elevation of spirit, but rather the opposite. She has become a nation to which might almost be applied the lines of Goldsmith regarding Holland:

> "Ill fares the land, to hastening ills the prey—
> Where wealth accumulates and men decay."

Perhaps it is not quite as bad as this, nevertheless the picture is not altogether without similitude. Literature, art and science,

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except as regards the application of the last to the development of wealth, have been largely side-tracked in the quest of the almighty dollar. High thinking has taken a back seat and has been supplanted by high finance and corrupt politics. To those who saw deeply into the problems of the present conflict it was evident from the first that this nation must sooner or later become a party to the struggle, and yet our psychology was controlled by a dominant idea that we must keep out of the war lest our pockets and our comfort be affected. The impulse to righteousness and the love of adventure were submerged. America's attitude was partly one of indifference and partly one engendered by a feeling of security. At last, however, the nation has found herself.

A Federation for Peace.

One of the questions most frequently asked to-day is, What will be the results on human happiness and prosperity of the present great war? Some hold it will work for good; some believe that the immediate and eventual evil will overbalance the good. We are not in this connection concerned with a discussion of the material evils or the material good present or to come. We ask ourselves rather what will be the psychological effects of the war upon nations and upon international relations. One view increasingly held is that out of the terrible turmoil will come an international federation for peace. Those who hold it are not always clear as to the manner in which this will come. I believe the idea, at least as it has mostly been expressed, is not likely to be realized. Nations will not unite in a federation for peace, unless each of the contracting parties is strong enough to defend its rights and its position in case of war. Lack of preparedness, so far as some of the belligerents are concerned, has been one of the sad features of the gigantic struggle and this in its turn has been largely due to the deluding psychology of some of the participants. The smaller states especially, and among the greater nations England, were sadly unprepared for the conflict. America, at last taking the stand which has all along been inevitable, finds herself also unprepared and this largely because of the strange psychology which kept the nation from a realization of the inevitableness of its entry into the strife.

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One of the most beneficent results of the present great war will be the intensification of a more or less universal feeling for the sacredness of national rights. A federation for peace would have to be based upon the acquiescence of all parties to such a scheme and this in its turn would depend upon the development of a self-confident national spirit in every nation concerned. Our own country is as strong as the states which compose it are strong. A great university has strength in accordance with the strength of its more or less autonomous constituents. This war will produce an international psychology based upon national ideals. No nation has ever been completely crushed, unless the forces working against it have been such as to practically wipe it from the face of the earth, as illustrated in the story of Rome and Carthage.

Out of the present war every nation engaged will come retaining its nationality. Even the tottering empire of Turkey will remain, although in all probability much shorn, especially of its European territory. What we may be pleased to call new nations, will arise, but these in reality will be simply the revivals of nations which have never lost the national spirit—nations, for instance, like Poland and possibly Finland.

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OUGHT LIMITED RESPONSIBILITY TO BE RECOGNIZED BY THE COURTS?

By CHARLES P. BANCROFT, M. D.,
Superintendent, New Hampshire State Hospital.

The problem of criminal responsibility is perennial. The only apology for any contribution upon such a time-worn theme is the lure of its many intricate and interesting phases. Two opinions have prevailed; one, that the fixing of responsibility is outside the physician's province; the other, that the problem is distinctly medical because any consideration of responsibility involves a study of mental states in the transgressor, and such investigation requires for its prosecution the experience of the trained psychiatrist. At one time the writer was inclined to favor the opinion that the fixing of responsibility was not within the physician's competence, although his interrogation by the court on this point would be perfectly admissable. Subsequent observation has modified this earlier impression and led to the conviction that the determination of responsibility is essentially a medical proposition for reasons which will appear within this paper. One frequently hears that any discussion on responsibility is chiefly academic, has been worn threadbare during the last 50 years, and is therefore profitless. Such reasoning is specious and does not satisfy the craving of the legal and medical professions for common ground on which both may meet with mutual satisfaction.

At a notable congress of alienists and neurologists held at Geneva and Lausanne about 10 years ago, a lively discussion occurred on what the attitude of the medical profession should be toward the metaphysico-legal idea of responsibility. Ballet and Grasset debated the subject. A large majority of the congress agreed with Ballet that "since questions of responsibility are of a metaphysical and juridical order and outside the physician's competence, a judge is not entitled to demand the physician's opinion concerning them." (Havelock Ellis, *Journal of Mental Science*, Vol. 54, p. 155.)

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More convincing appears the opinion of Toulouse and Crinon in an article published in the *Psychiatric Review* in 1906. These medical writers favored the idea that the "problem of penal responsibility is a psychological problem" and that inasmuch as responsibility cannot be determined without a careful examination of the mental state of criminals "expert advice must be sought." They insist that only the physician trained in modern psychological methods would be qualified to render such advice. Expert advice thus secured would become of great assistance to the court, who, either rejecting or utilizing the knowledge thus obtained, would be materially aided in fixing the degree of responsibility and prescribing the penalization. (Havelock Ellis, *Journal of Mental Science,* Vol. 53, pp. 195, 196.)

The attempt of certain jurists to clarify the situation by postulating a "medical" and a "legal" insanity is misleading and scientifically inaccurate. In fact such pseudo-classification is merely a reversion to Lord Hale's famous dictum of a "total" and a "partial" insanity. The endeavor to partition the mind, saying that one portion may be diseased and the other intact, and that the entire mind must be affected to constitute legal insanity, is futile because such procedure is inconsistent with mental pathology.

Ballet insisted that the question of responsibility is a metaphysical one, does not concern the medical profession, and should ultimately be determined by the court. According to this interpretation the alienist's obligation ceases when he has pronounced the individual either sane or insane; the placing of responsibility, being a non-medical matter, would then rest with the court. Neither the medical nor a large portion of the legal profession will readily assent to this conclusion. Psychical processes play so prominent a part in the genesis of responsibility and are so vitally affected by either functional or organic disturbance of the brain that the problem must be largely medical and ultimately determined by the alienist. The jurist cannot afford to ignore the aid of the physician and must be guided by his experience. Court procedure confirms the material value of medical assistance. Advocates constantly press the alienist for his opinion regarding the responsibility of the person under trial in spite of various theories that have prevailed from time to time concerning his competence to render such opinion.

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At this point the legal profession, through misconception of the nature of mental processes, err in expecting that the medical expert will draw an exact line of demarcation between absolute responsibility and complete irresponsibility. The lawyer desires the physician to apply some sort of psychological yardstick and state the exact point at which responsibility ceases and irresponsibility begins. No middle ground is desired. To anyone familiar with mental processes such accurate measurements and lines of demarcation are known to be absolutely impossible. The mental mechanisms upon which conduct and responsibility rest cannot be registered with the same mathematical precision as the cylinder bore of the gasoline engine. Imperceptible gradations between different mental processes and their final expression in conduct presuppose varying degrees of responsibility passing gradually from full responsibility through various shades of modified and attenuated responsibility down to total irresponsibility.

Abrupt and well defined lines of demarcation between full responsibility and total irresponsibility cannot therefore always be drawn. The lawyer must not expect mathematical boundary lines between immaterial mental states. Gentle gradations rather will mark the transition between different mental mechanisms and their final expression in conduct. Generally the psychiatrist can with fair accuracy connote total irresponsibility, total responsibility, and modified responsibility.

In 1907 appeared Grasset's book on "The Semi-Insane and the Semi-Responsible," translated by Jelliffe. The author elaborates the arguments in favor of and against the recognition of "attenuated responsibility." Grasset firmly believes that the "question of responsibility is by no means metaphysical, but it is psychological; consequently it is also a medical question." (*Op. cit.*, p. 379.) One of his conclusions has much practical significance: "When a semi-insane individual has committed a misdemeanor or crime, he should be both punished and treated at the same time." (*Op. cit.*, p. 397.)

The latest contribution on the subject of modified responsibility is an atricle on "Insanity and Criminal Responsibility" in the *Harvard Law Review* for April, 1917, by Edwin R. Keeley, chairman of a committee for determining the relation of insanity to criminal responsibility. This committee presented to the Institute

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of Criminal Law and Criminology a Criminal Responsibility Bill. This bill was criticized by the editor of the *Harvard Law Review*. One of the criticisms was that the proposed bill of the committee "will introduce the doctrine of partial responsibility, *i. e.*, the holding of lunatics for part of their crimes." (*Harvard Law Review*, April, 1917, p. 538.) To this criticism Professor Keeley, in his reply, upholds the recognition of partial responsibility, contending that partial responsibility in no way involves partial insanity. He says: "The editor suggested that the adoption of the doctrine of partial responsibility would lead to compromise verdicts when the evidence is conflicting. It is submitted that this result is not nearly so likely to happen as is the acquittal, under the present rules, of a defendant who is known to have lacked some of the mental element necessary for the full crime charged. Illogical verdicts are more likely to result from illogical than from logical rules." (*Ibid.*, p. 554.)

The question of responsibility is closely identified with that of punishment. The two are intimately associated in our minds. Subconsciously our notions about responsibility are influenced by various social, moral, and religious conceptions concerning punishment which are the outgrowth of experience or are the heritage of the past. It is needless to add that responsibility and punishment for guilt must be entirely dissociated in our minds while attempting to solve the question of personal responsibility. Whether punishment is part of the teleological scheme of the universe does not concern us here. We do know that centuries ago, society, for its own protection and on the assumption that all men were responsible, devised a system of punishment for wrong-doers. In earlier days cruel punishments were exacted. Their severity and injustice marked the misconception of the lawgivers who secured their legislative enactment. At first punishment was retaliatory—a squaring of accounts between society and the criminal. Later its purpose was conceived as mainly deterrent. The penologist of the present day insists that the chief aim of punishment is the reformation of the criminal, securing if possible his return to a normal and useful life. While social expediency insists that the criminal shall be punished, the hope is expressed that recognition of individual limitation will receive careful consideration in determining the degree of personal responsibility. Punishment should

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be made to fit the individual rather than the crime. The indeterminate sentence facilitates this intention. When the criminal sees a new light, in other words is reformed, the necessity for further punishment ceases. Modern prison reform is based on a rational psychology. At the same time we must remember that punishment does exercise a salutary influence upon the semi-responsible mind, supplying an incentive toward right conduct that does not seem possible of attainment in any other way. A reformatory sentence may prove to be a wiser dispensation for a semi-responsible offender than confinement in an asylum. Such person may require the discipline and the more exacting régime of the reformatory to supply him with initiative toward right doing and stability of purpose entirely lacking in his original makeup. His punishment achieves a therapeutic end. By confining such a semi-responsible in a reformatory the interests of society are conserved, the object lesson upon other malefactors with similar mental limitations is not lost, and the criminal himself receives a possible benefit. If further treatment is required transfer to a hospital for the insane is always possible. Sentimental leniency may prove harmful in the semi-responsible person. It is in such cases that Ballet's conclusion becomes applicable; "the semi-insane individual who has committed a misdemeanor or crime should be both punished and treated at the same time." The potential therapeutic mission of the true reformatory must never be forgotten. For certain defectives the reformatory may be preferable to the asylum.

Responsibility is practically liability for wrong doing. What is the state of mind that makes a person liable for his misdeeds? To be liable for wrong doing a person must be able to reflect upon the nature and consequences of his act, to consider and weigh the various motives leading to its performance, to consider whether the act is merely selfish and thereby harmful to others, whether in fact the act is wrong in the light of the moral, the common or the statutory law, and finally he must possess the power to make a decision in his own mind whether to do or not to do the act. Liability presupposes the ability to exercise reason, apply corrective judgment, and the power to choose between different courses of action. Motiveless acts are evidence of insanity and irresponsibility. (Mercier, Criminal Responsibility, p. 156.) The

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insane person justifies his action. He cannot think his conduct is wrong, because from all the reasoning at his command he believes that he is right, and what he does must be justifiable. To his impaired corrective judgment the established laws of society make no appeal, nor do they exercise upon his distorted mental perspective any restraining influence.

Responsibility or liability must be measured by the degree of judgment and will power of the individual. These mental states vary in the normal person. Temperament exerts a profound influence upon conduct in the perfectly sane and responsible person. A man with what we say is a normal mental equipment, under the stress of strong passion, may be so upset by storms of feeling as to become the victim of his own impulsivity, still we say he is responsible because be could and should have weighed the consequences, and should have exercised his will-power to control his conduct. Another man with bad hereditary antecedents, brought up in wretched environment, with limited education, absolutely no moral instruction, depraved tastes and associates, and a meager mental equipment cannot be held to the same standard of liability as the former more favored and better endowed individual. In other words identical standards of responsibility do not apply alike to all individuals. Liability varies with the person. The moron, or high-grade imbecile, ought not to be measured by the same standard of responsibility as the normal person, or the low-grade imbecile, or the idiot.

Where shall we draw the line between the wholly responsible and the semi-responsible? The problem is difficult and can only be solved by a searching analysis of the individual case. In this analysis underlying motives must be registered accurately. Bad heredity alone is not sufficient ground on which to exonerate wrong doing. Too great emphasis is not infrequently laid at the door of inherited evil tendencies. Of far greater importance is the character of the judgment, the reasoning capacity, and the will-power of the criminal offender. The defects in these mental processes demand for their detection long continued, intensive study. This end is better secured by commitment of the criminal for observation to a hospital for the insane than by a superficial examination attempted in the ordinary jail. Of especial value is such study in the borderline case, the psychopath, the constitutionally inferior

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man, the sexual pervert, any individual that falls short of unquestionable insanity but still exhibits a manifest deviation from normal mind. The records of the criminal courts are filled with such cases. It is in such cases as these that varying degrees of departure from normal mind are accompanied by corresponding modifications of individual responsibility. The sexual pervert who, while holding positions of trust and maintaining a semblance of respectability and religiosity, secretly yields to indulgence in filthy practices until a vicious habit is formed, is certainly more responsible than the old man guilty for the first time of similar practices, whose mind is crumbling in an incipient senile dementia.

When modified responsibility is recognized by the courts as a logical conclusion founded on a scientific psycho-pathology, then the psychiatrist can make to the court a report that is entirely consistent with our present knowledge of normal and abnormal mental processes. He will feel that he is not playing into the hands of the partisan lawyer, but is expressing an opinion founded on sound data. Such conclusion and final report to the court are in harmony with our knowledge of mental mechanisms and their conduct reactions. The alienist, in recognizing modified responsibility and its important relation to conduct, does not stultify himself by expressing opinions which he really knows are inconsistent with sound pathology.

In states still retaining capital punishment the doctrine of modified responsibility is especially helpful. In these communities it not infrequently happens that a homicide is committed by some person whose mentality does not measure up to normal, and who manifestly falls short of full responsibility. The individual may pass the ordinary superficial tests of responsibility, such as knowledge of the nature and quality of the act, whether it was right or wrong, etc., and yet one is satisfied that the prisoner's reasoning powers are so limited, his capacity for exercising comparative judgment is so restricted, that there is a manifest reduction of the will and with this defect a modified responsibility. With capital punishment ever before him, the alienist must either declare the prisoner wholly irresponsible in order that the semi-responsible man may escape a senseless execution, or he must pronounce the prisoner wholly responsible and trust to the hope that executive clemency will in the end save the state from the charge of having

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committed "judicial murder." Such paradoxical situations will be avoided by a recognition of the doctrine of modified responsibility. Under such procedure the alienist will make a report to the court that is consistent with the actual mental status of the prisoner. Even with the actually insane person the most intensive study is desirable in order that a definite understanding may be reached as to the extent that the mental disease has invaded the domain of judgment and will-power and to what degree personal responsibility has been impaired.

Recognizing the rational basis of the doctrine of limited responsibility, the following conclusions appear to the writer psychologically consistent, presenting a course—a *modus vivendi* that ought to be mutually acceptable to the court, the jury, and the expert:

I. The physician's competence does extend to the determining of responsibility.

II. Every case is potentially different from every other case, and therefore calls for special individual study.

III. No general inclusive juridical rule can be devised that will fit alike all cases in which the question of responsibility is raised.

IV. The finding of a mental status involving responsibility, irresponsibility, and limited responsibility is based on rational psychology and ought to be logically satisfactory to both the medical and legal professions.

DISCUSSION.

DR. WILLIAM A. WHITE.—Mr. President, I have read a good many papers on criminal responsibility and criminal insanity and all that sort of thing and we always seem to be left where we began, with such discussions. It has helped me to think of it in another way and it might help others. Responsibility does not seem to me as something that can be conceived as resident within the alleged criminal. It is not a property that he has, psychologically or otherwise. It is a label pinned upon him by society represented by the jury. It is the critique of society which it has reached through and by the herd through its representative, the jury; in other words, responsibility does not reside in the alleged criminal, it is the critique of the herd. That is the situation at bottom. And I don't believe we can get a very accurate idea of responsibility unless we are able to think of it in that way and I think that is fairly demonstrated by a number of things.

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In the first place, we have many compromise verdicts; we have the jury bringing in verdicts for crimes which the individual could not possibly have committed. Then we have the history of the ideas of responsibility. Originally, there was no connection between the punishment and the individual who was supposed to have committed the crime. Originally, some anti-social act was done. Nobody knew why, or understood how, it occurred and none cared whether the person accused was the one who did it or not. So that society tried to retaliate by punishing an individual for *an* anti-social act; and it was only a later psychological development that let it hitch up the actor with the punishment, and even to-day the question is one that lies with the jury. One individual that has committed a certain class of crime is sure to be executed no matter what is done for him; certain other individuals are certain to be let off no matter what is said by the prosecutor. So that in reality the jury looks over the situation, they apply the law of love or hate as they may be influenced by it, and, if they feel that the prisoner ought to be exterminated, they say he is responsible. If, for any other reason, they think he is a proper object for sympathy, they say he is irresponsible and "we will let him off." So if we can say that it is an end by which retaliation or sympathy may be attained it will enlighten the whole situation very much.

DR. HARRIS.—Mr. President, this subject is one about which I feel very strongly, and, consequently, I was greatly delighted to hear the paper read and to listen to the ensuing discussion. My attitude toward this class is that no case should go before a court until a proper mental study has been made to determine the actual mental status. When we are able to get the communities and courts to operate with the medical profession in this way, we shall arrive at the point where we can fit the punishment to the crime. We should not try to punish the individual for the crime committed until we have given the proper attention to the intellectual development. In order to bring about the greatest good, of course we should begin with the proper study and training of children in early life and follow them through their school days—in other words, the application of proper mental hygiene in the development of the individual, and it appears to me that this is the only way in which we can determine the best course to pursue in regard to the ultimate disposition of any delinquent case.

DR. BANCROFT.—Mr. President, the thought has often occurred to me that the alienist in expressing his own opinion in certain cases could voice his own mental attitude more satisfactorily by a return to the court of sanity or insanity, as the case might be, with a possible accompanying mental reservation of modified or weakened responsibility. By such qualification the alienist does not subscribe to an impossible arbitrary line of demarcation between different mental states, between entire sanity and entire insanity, neither does he seem to be catering to the

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views of possibly partisan and prejudiced counsel who in their zeal desire to force the physician to an expression of a radical opinion.

The speaker has had occasion this very spring to give evidence in a case of premeditated murder in New Hampshire. The murder was committed by an individual who might possibly be called a moron. The crime was evidently premeditated, and of his own voluntary part in the homicide I was quite satisfied.

The prisoner was able to pass an intelligence test of only about 11 years of age, but his crime was a deliberately planned and cold-blooded, vindictive act, undertaken and carried through with clear understanding as to its nature and consequence. With a bad heredity, a poor home environment and bringing up, and an evident weak power of control, the question of modified responsibility very naturally occurred. The prisoner himself clearly recognized his plight, was extremely anxious to escape execution for the sake of his young son, and was anxious to plead murder in the second degree. This plea was the result of conferences between counsel for the defense and counsel for the state brought about by the speaker. Both the state and the defense finally accepted a condition of modified responsibility as a fair representation of the prisoner's mental capacity. A verdict of murder in the second degree, a long term in the state prison, satisfied the ends of justice, and was willingly accepted by the prisoner. The recognition of weakened responsibility—the logical sequence of a mind slightly deviated from the normal, became in this particular case a satisfactory disposition of a somewhat perplexing problem. Execution of this man would have been nothing better than judicial murder. Confinement in a state hospital would have defeated the aims of justice by classifying a semi-responsible with the entirely irresponsible. The middle course pursued became in the end the most logical and the most just course to the prisoner, the public, and the court.

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THE NEED OF CLOSER RELATIONSHIP BETWEEN PSYCHIATRY AND THE MEDICAL SCHOOLS.

By MAJOR ARTHUR H. RUGGLES, M. D., M. O. R. C.,
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We are now in a period of educational reconstruction, and at such a time it may not be amiss to suggest methods of teaching that will be of service in the changing order of things.

Nine years ago, there were in the medical schools of this country, a little over 25,000 students. In 1916 there were approximately 15,000 and I need not remind any member of this society that in those eight years the positions open to graduates of our medical schools have almost doubled. The contemplation of this question of medical demand and supply is a most serious one, but it is not with that question that I am now dealing. Psychiatry to-day needs a greater number of men in its ranks and these men should have the best possible training for their specialty. It is concerning the ways and means of attaining this end that I wish to engage your attention.

What field of medicine offers more or wider opportunity in the immediate future than ours? The development of neuropathology and serology, the relationship of the ductless glands to the nervous system, metabolic studies, shell shock and other war psychoses, a splitting up of some of the large groups of mental diseases into more accurate subdivisions—all these subjects show the magnitude of the work to be done. What can be a greater incentive to the ambitious medical-school graduate than a field of endeavor in which there is so much new work to be undertaken? We are still in the formative period of diagnosis and when we have developed to the point of accuracy attained by those studying chest or abdominal conditions, what a new field of treatment will open before us. And the men that become interested in this branch of medicine, should they not start with a better psychiatric equipment than was obtainable for most of us? Having then established my premises, namely, that it is desirable to interest more men in psychiatry and that these men should have the best possible equip-

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ment for their chosen work, I wish to offer for your consideration the following suggestions: 1st, the need of a higher and more uniform standard of psychiatric training in our medical schools; 2d, the requirement of psychiatric knowledge for state registration; 3d, the dissemination of knowledge of the psychiatric opportunities to the men in our medical schools; 4th, better opportunities for post-graduate study in psychiatry; 5th, introduction of case-teaching system between medical schools, institutions and the specialist in private practice.

The Need of a Higher and More Uniform Standard of Psychiatric Teaching in Medical Schools.

A study of the required courses in psychiatry in the leading medical colleges of this country shows a widely differing standard of teaching. A few of the schools provide courses in which, besides the usual didactic lectures and clinical demonstrations, the student must himself examine patients—a very few of these schools make these practical courses compulsory. Two or three schools provide opportunity for the fourth-year men to study and examine carefully a number of cases. This should be a requirement in every class A medical school.

Together with the lectures already provided in most of our schools, should be offered better teaching in normal and abnormal psychology. This, of course, is the function primarily of the college, but coöperation between medical-school teacher and psychology professor might lead to better preparation of the student for his medical-school courses dealing with disease of the mind. Several of our medical schools give courses in "Psychology as related to Psychiatry" and this should be followed by all. Neuropathology now has a place in the curriculum of practically all schools, but many fail to require each student to study the lesions of the important nervous and mental disorders under his own microscope, and this is essential to a thorough understanding of clinical psychiatry. We would not expect that physician who has never examined a diseased chest to recognize incipient tuberculosis in his patient, and yet we wonder that mental cases coming under the care of the specialist are usually far from incipient, although we know that a majority of the medical men coming from our schools have carefully examined a half dozen cases of mental disorder.

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And how are we to get our cases early if the general medical practitioner is not trained in the recognition of the early symptoms? It is a *sine qua non* that the teachers of psychiatry shall have at their immediate command a wealth of psychiatric material, and this can of course best be accomplished only if they are connected with a modern psychopathic hospital.

Another course that should be found in the medical-school curriculum available for the man desiring to enter the field of mental medicine, is one in mental hygiene that shall deal with the factors causing mental disorder, their prevention and the treatment of pre-psychotic symptoms. Such a course should include practical instruction in methods of testing the degree of mental development and ways of training the mental defective. The day is not far distant, I hope, when the medical school offering less than the work I have briefly outlined, will be considered a second-rate school.

The Requirement of Psychiatric Knowledge for State Registration.

At the present time the state board examination that asks a question concerning mental disease is a rarity. A physician who has never seen a case of mental disease can pass the examination for registration in medicine in any state in the union, and yet we wonder that many cases of mental illness have been under treatment by their physician for many months before the nature of their malady is even suspected.

Certain foreign countries require a whole day given up to examination in the knowledge of disorders of the mind, and yet this country devotes not even five minutes to this requirement. Is a reform in this direction not necessary before psychiatry can expect to come into its own?

Dissemination of Knowledge of Psychiatric Opportunities to Men in Medical Schools.

With more courses added to our curriculum and with many of these required, it is obvious that a greater number of men will have an interest in psychiatry aroused, but I think that more than this should be done. We see more and more of what is called ethical advertising, which is nowadays done in a thousand different

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and effective ways. Should we not put before the medical student in his first year an outline of the purpose of the courses in psychiatry, and follow that up with talks by members of the department concerning the many opportunities open for a man having a desire to specialize along this line? Furthermore, the opportunity for research in this branch of medicine should be presented to the second and third year students, and institutions should open their doors to men who have had two or more years in the medical school, for work during the summer months, as laboratory assistants or clinical clerks, and should make these positions attractive by some financial return. It is only by getting men actually in touch with our work and its opportunities before their medical career has actually been entered upon, that we can hope to attract any increasing number of men into the work.

Better Opportunities for Post-Graduate Study.

Not infrequently a man goes into general practice and in a few years wishes to specialize. Perhaps he would like to do mental medicine, but sees no opportunity to get special training in this branch in any nearby city, while there are plenty of courses or opportunities offered, training him in pediatrics, laryngology, otology, surgery and many other branches of medical science.

With the establishment of modern psychopathic hospitals, such training can be and has, in a few places, been offered. Every medical school should provide organized post-graduate work in neurology and psychiatry, so that a medical man could take a year or eighteen months' course providing adequate instruction and the opportunity to diagnose and treat a great number of cases of nervous and mental disorder. Such a course should be made as intensive as possible, providing definite work in the laboratory, wards and out-patient departments, and freeing such post-graduate students as much as possible from the routine work involved in administration problems.

Introduction of Case-Teaching System Between Medical Schools, Institutions and the Specialist in Private Practice.

The method of case-teaching, as carried on at the Massachusetts General Hospital by sending case records to a large number of subscribers, might well be instituted by some psychiatric center.

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What a boon it would be for many of us to get each week the abstract of cases presented at staff conferences, with the different medical opinions upon them, and where the case has come to autopsy, the report of the pathologist! In this way new methods of examination and treatment could be disseminated among us. New points of view regarding psychoses could be gained, and these case reports would serve as a most valuable method of instruction for medical-school classes in psychiatry and for the younger as well as older members of hospital staffs, and also for the private practitioner who does not see the great number of cases of mental illness that the man in an active state hospital does. I can readily see where a year devoted to case-teaching, dealing with the differential diagnosis between early cases of manic-depressive insanity and dementia præcox, would be of the greatest value to us all. The hospital conducting such a course might well invite reports of cases from various institutions and take those which are best worked up and of greatest instructive value to add to those that they shall send out. In this way each one of us by paying a modest fee could have access to from 100 to 200 cases a year. Each case illustrating points of interest in differential diagnosis, new methods of examination or treatment, or mistakes in diagnosis as shown in the autopsy room or by the unexpected termination of the case in recovery or dementia.

In closing, should not each one of us undertake the task of encouraging well-trained medical students to enter psychiatry, to raise the standards of psychiatric teaching in this country, to stimulate a greater coöperation between those working in mental medicine and to help in a wider dissemination of psychiatric knowledge?

DISCUSSION.

DR. BANCROFT.—Mr. President, it seems to me almost a pity that so important a subject should go by without any discussion or remark. I believe that the Doctor has well emphasized the necessity of a closer relationship between our specialty, psychiatry, and the medical schools. I don't know whether this Association has ever made any definite attempt to enlist the interest of the medical schools in this particular branch of medicine or not, but I believe that sometime this Association should take up the matter in earnest. It seems to me that the suggestion made that psychiatric examinations should play some part in the securing of state registration would be one way in which the medical schools and the general medical practi-

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tioner might become interested in the importance of psychiatric training in their medical studies. In the rural districts I believe that a better psychiatric knowledge would be of great benefit to the general practitioner. In the large centers, of course, this particular branch of medicine is cared for by the specialists; but in the country, in the state which I represent, at least, there is a lamentable ignorance on the part of the general practitioner as to the general fundamentals of insanity; and yet the general practitioner is brought into close contact with this specialty in his daily practice in the rural district. There are many important questions coming up in the proper conduct of the case in the private family in the country where such training would be of greatest value, not only to the physician himself in handling the case properly but also in giving proper advice to the family. I believe, Mr. President, that this is a very important subject and sometime—I hope not far distant—this Association will impress upon the medical schools the importance of emphasizing a broader training in psychiatry, and I know of no better way than by making psychiatric examinations one of the important essentials in the conferring of state registration.

DR. LOCKE.—Mr. President, this matter is of particular interest to me as a teacher, and I think possibly it may be to others who are so engaged. If I may, I will add a few words to what has already been said in setting forth a few of the difficulties which come to the teacher, particularly one who is teaching in a college in the rural districts like my own—the Syracuse University. Of course, the work in connection with the state hospital is of very great value in demonstrating mental diseases to your students, but the trouble with the state hospital is that the cases there are manifestly developed. They may be problematical in regard to the etiology and in regard to the diagnosis. Now, that is not what the practitioner in the country districts needs so much. What I try to teach the student as he leaves the college is to the end that he may be able to recognize mental disease in its earlier stages and in order that he may intelligently direct whatever is necessary and desirable to reduce the mental morbidity of the district in which he practices. Now, the state hospitals are, of course, extremely helpful; but it is in the psychopathic clinic—where the incipient cases appear—that our instruction is, I think, of very great importance, and it is in this connection that I would like to have any assistance of a practical kind that anyone can give me. I have a psychopathic clinic. We have a dispensary—a modern, fully equipped dispensary—at Syracuse. The patients are admitted to the various departments of the dispensary by the registrar, or through the office with which he is connected, and the diagnosis is very largely made by him. A patient comes in and says he has stomache ache, or back ache, or sees double or something of that sort and is referred by the intelligent office assistant to the gynecological, orthopedic or opthalmological class; that is, he is referred to whatsoever class his own localization of his disorder may indicate; and very much of the time the patient stays there. The older men who are in charge of these departments, and who have had no training in psychiatry, treat a group of somatic symptoms of a purely

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psychotic foundation. My students tell me that they can go into the other classes and get sufficient material to fill my class to overflowing. Patients are being treated for all manner of difficulties which, as a matter of fact, they do not have. The problem is—just how may we round up this material which is passing through the admitting office of every dispensary and divert it to the psychopathic clinic where it may be used for instruction purposes; particularly, to demonstrate the earlier manifestations of mental disease. We must so instruct our students that they may be able to discover and comprehend the incipient symptoms of mental disease when they find them—on the farm, the active business house and in the dispensary. It is here that we must hope to obtain the best results from instruction rather than in the observation of the completely developed product which largely obtains in the state hospitals.

DR. HARRIS.—Mr. President, I have been much interested in Dr. Locke's description of his troubles, in relation to material furnished by the state hospital, and in connection with the troubles the students are likely to encounter when meeting with cases in general practice. It is very true that the family physician first comes in contact with patients showing mental symptoms and that it is therefore all the more reason why the medical schools should teach psychiatry, the most important branch of medicine. The study of this disease and its treatment should be made a subject of special attention in the medical colleges, and then it seems to me we would not have the great trouble about which there is so much complaint. I think it unfortunate that the disposal of cases coming into any dispensary is left to a clerk rather than to a physician, who at least has some knowledge of medical conditions.

DR. RUGGLES.—Mr. President, I was interested in looking up the amount of teaching coming along these general lines in different schools to find just what they were doing and I was struck with this fact, that the best schools are apparently fully meeting the needs of the situation. The teaching has become much more intensive, the instruction has become much more active, and the problem is being well dealt with. However, of the 90 odd medical schools in the country a majority have not provided anything like adequate teaching in psychiatry and that is the point I wanted to emphasize. While the best schools are already doing this work, there are a lot of schools that are not doing it and they should be influenced by the opinion of a society like this into doing it. Dr. Locke's point, as to getting other material for teaching, would seem at least in a measure to be nearly met by the observation hospitals where the early mental cases are sent for mental observation, not only for the protection of the public, but also for this very purpose of teaching a knowledge of mental symptoms to the students. I am sure that a number of those who work in psychopathic hospitals will say that these hospitals are securing a great amount of material for teaching and in addition the general hospitals have a great number of cases of this kind for the medical student.

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PSYCHIATRIC PROBLEMS AT LARGE.

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On July 1, 1916, an enumeration of cases of mental disorder, both in and out of institutions, was undertaken in Nassau County, New York. A method was applied which was calculated to bring to light more especially cases of sociological significance. These cases were, however, also studied from the medical viewpoint, so that eventually the material that had been gathered came to be classified in a twofold manner, according to a medical and a sociological classification.

The investigation was conducted by a method consisting essentially of two stages. The first stage consisted in securing *leads* to cases of probable mental abnormality in the county; and the second, in efforts to secure *data* concerning these cases sufficient to establish the abnormality, if it indeed was there, and to determine at least roughly its nature.

The main sources of leads were as follows: (1) lists furnished by the State Department of Charities, Eugenics Record Office, and Nassau County Association and other charitable organizations in the county; (2) the records of the overseers of the poor; (3) the records of the justices of the peace, police justices, and the district attorney; (4) the records in the county clerk's office of divorce and separation proceedings; (5) lists furnished by neighborhood workers, district nurses, truant officers, clergymen, old residents, and other persons; (6) lists furnished by practicing physicians; (7) cases examined in state hospitals and public and private charitable institutions and in penal and correctional institutions, and (8) cases found in the elementary public schools.

The near relatives of all "abnormal" persons living in the county were also investigated, and among them were found many whom we classified as mentally abnormal and to whom no leads were available from any of the above-mentioned sources.

For purposes of control four districts in the county were selected for intensive investigation by a house to house canvass intended to

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subject every resident to examination; the total population of these four districts is 4668.

The findings may be summarized as follows: In all 1592 "abnormal" individuals were found. These figures are exclusive of the data gathered in the schools, for the collection and study of which separate provision was made through the cooperation of the United States Public Health Service.

The total population of the county, according to the last census, made by the state in 1915, was 115,827. On this basis the percentage of mentally abnormal persons in the county is found, by calculation, to be 1.37. By including an estimated number of abnormal children found in the public schools, based on data furnished by Surgeon Taliaferro Clark who was in charge of that part of the work, the percentage would be 1.72.

Clinically the "abnormal" cases may be divided into four main groups, as follows:

Insane	394
Epileptic	72
Feeble-minded	634
Constitutionally inferior (inebriates, criminals, prostitutes, chronic dependents, etc.)	492

Not all these cases, by any means, would require institutional treatment—according to the judgment of the medical officers of the survey, only 59.4 per cent. Moreover, for many of the cases, institutional treatment is already available; this is true especially of the insane and, to some extent, of the epileptic and the feeble-minded.

The survey has shown very clearly that for the bulk of cases presenting psychiatric problems, the benefit of psychiatric study, judgment and treatment was not available. These cases are now in the hands of the police, justices of the peace, overseers of the poor, church and private charitable organizations and general medical practitioners.

Similarly, psychiatric problems in cases among school children are left without attention, or, seemingly, even deliberately avoided. The medical examination of children in schools takes into account height, weight, chest expansion, eyes, ears, nose, tonsils, teeth, etc., but not mental condition. Save by way of rare exception, where a special class is provided for retarded children, mental abnormalities or peculiarities receive no attention on the part of the educa-

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tional authorities. This is prejudicial not only to the interests of the abnormal children but of the others as well.

The fact is, that the psychiatric basis of many cases of retardation in school, criminal tendency, inebriety, drug habits and pauperism is hardly recognized even by medical practitioners. It is, I think, owing to this circumstance that mental clinics, especially in rural or semi-rural places, have heretofore failed to realize their full possibilities for service.

The usual practice has been merely to organize a clinic and to open its doors to those who would, of their own accord, seek psychiatric advice, or who would be sent or brought to the clinic for that purpose by their relatives or physicians. At some of the clinics attendance has seemingly depended on advertisement, falling off rapidly when advertisement was not kept up.

The great problem, evidently, is to bring to the clinic cases which are of a psychiatric nature, but not necessarily recognized as such by general practitioners, by laymen, or by the patients themselves.

Perhaps the best plan would be to organize a system of cooperation between the mental clinic and public authorities who have to deal with problems of social maladjustment, such as often arise on a psychiatric basis: (1) school principals having to deal with retardation, truancy, unruliness; (2) justices of the peace, police justices, district attorneys and county judges having to deal with crime, inebriety, vagrancy, prostitution, etc.; (3) overseers of the poor, county superintendents of the poor and charitable organizations having to deal with dependency.

In large urban centers it is perhaps not so important, though none the less desirable and advantageous, for an out-patient mental clinic to establish such connections; the functions of the mental clinic are vicariously performed for the police, the courts, the schools and charitable organizations by neurological clinics, by "clearing houses" for mental defectives, or by psychiatrists especially employed for such purposes. In rural or semi-rural places no such assistance is, as a rule, available; and, when made available through the establishment of a mental clinic, is not apt to be made use of to any great extent in a spontaneous way, as the communities have not yet been educated to the point of discerning a psychiatric problem, as such, where it exists.

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The experience of the Nassau County Survey has shown in a most striking way that large opportunities for psychiatric service would develop if the medical staffs of the mental clinics would undertake regular inspections of schools, almshouses, charitable homes, jails, penitentiaries, prisons, etc.

It has been customary heretofore to hold out-patient mental clinics at stated regular times, either fortnightly, or weekly, or perhaps somewhat more often. This does not afford an opportunity for psychiatric consultations which may be sought in the intervals. In order to provide such an opportunity, each state hospital conducting an out-patient mental clinic should arrange for the psychiatric examinations of persons brought to it for that purpose at any time, and the law should permit the detention of such persons for observation for a period of 10 days upon an order of a magistrate.

As it is not always convenient or even possible to bring patients either to the out-patient clinic or to the state hospital, some provision would seem necessary whereby a state hospital would be ready at any time to send a member of its medical staff to any part of the hospital district for psychiatric consultation upon the request of a proper authority.

It is not to be assumed that even such an organization of out-patient mental clinics as is here advocated would provide fully such psychiatric service as the communities need; it would merely place the state hospital in closer touch with psychiatric problems arising at large in its district, and make available for the community unrestricted psychiatric consultation and advice. In order to make possible for the state hospitals to render remedial service in full measure, as needed they must somehow be empowered, in the first place, to furnish, through social service, relief from unfavorable environmental conditions, financial difficulties, unemployment, etc., which often appear as the direct cause of the social maladjustment; and, in the second place, to provide early institutional treatment for the cases in which it might seem necessary.

The first of these requirements would perhaps be fulfilled through such coöperation on the part of the poor law officials and charitable organizations as is described above.

The second could be met only by increase of institutional capacity. To-day, even in the most highly organized states, the crying need in the sphere of mental hygiene is for increase of

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institutional capacity. The state of New York, for instance—one of the foremost in the union in this respect—had, in 1910, 396.3 persons in institutions for the insane, epileptic, feeble-minded, etc., per 100,000 of its general population. The material brought to light in the course of the Nassau County Survey shows that, by a most conservative judgment, the state could double its institutional provision without the slightest danger of such increased provision proving to be in excess of actual needs.

I wish, before closing, to refer to a valuable by-product that would develop in the course of the growth of the out-patient clinic, if organized according to the plan here advocated; namely, a register of cases of mental disorder, if not complete, at least including all those cases which are of sufficient sociological import to have become the concern of public authorities. The records accumulated by the clinic would gradually develop into such a register.

Judging from the results of the Nassau County Survey, it may be anticipated that after several years' development such a register would show that the bulk of all crime, vice, dependency and other social maladjustments in a given community is attributable to a comparatively small fraction of its population. It stands to reason that problems presented by such evils could be much more successfully attacked with the aid of material that would be available in such a register than without it.

DISCUSSION.

DR. WILLIAM A. WHITE.—Mr. President, the papers that I have listened to recently have been rather confusing, although Dr. Swift seems to have digested them all and to agree with everything that has been said. Dr. MacDonald apparently predicts a time when psychiatry shall be doomed. There will be no more classes nor can we speak of them because that involves classification. Dr. Swift, therefore, won't be needed in those days; he will be eliminated and his methods of speech education shall be cast summarily away. All of which reminds me that language, after all, has a function, one part of which is to convey ideas, to put them in terms of dynamic psychology, to transmit energy. With all due apologies it has a function. Classifications are no good if the classifications run the individual who makes them, but those with some idea of values have thought it possible for some at least to run the classifications.

I rise to say particularly that I was very much pleased with Dr. Rosanoff's paper. The work done in the survey of Nassau County is a most admirable work and it is no particular abuse of language to tell what it is finding

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out and to classify the different grades of behavioristic maladaptations which it finds, not for classification alone but in endeavoring to *do* something with the problem; and that, after all, is what we try to do whenever we endeavor to classify our mental material in some sort of way so that it can be acted on effectively. Such a survey as this one of Nassau County gives us a rough approximate study of the social inadequacy which exists. It gives us the degree of social inadequacy and whether it is worth while to endeavor to do something with it or not; and whether we can agree with him on a program or not we can say that it is no iconoclastic tirade against something, though not clearly understood, but something that can be made of value if some one wants to do it.

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ESSENTIAL PHASES OF PSYCHOLOGY FOR MEDICAL SCHOOLS.

By WALTER B. SWIFT, M. D.,

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It is now a little over three years since the subject of psychology in medical schools has been discussed to any great length or been taken up by men of stand and reputation. Since that time psychology has opened up several new compartments; since that time some of the old phases have become more crystallized and more applied. And since that time medicine itself has become more deeply aware of its need of psychology.

The men who spoke at this symposium were Shepherd Ivory Franz, Adolph Meyer, Elmer E. Southard, John B. Watson and Morton Prince. Their papers were published together in the March 30 issue of the Journal of the American Medical Association in 1912. The compartments that psychology has since opened up are those of mental tests, developmental psychology, etc. The old phases that are now more crystallized are educational psychology and genetic psychology. Medicine now demands the psychologists and their work more than before, especially in the line of mental measurement, and slightly more perhaps in the relationship of the psychologist in a research way to psychiatry.

With these natural evolutions of our subject, and the new place that psychology is attaining to, it would seem quite apropos to take up this subject again and consider the matter from an entirely new standpoint in relation to the modern developments of these subjects. Psychology as a whole is admittedly too large to be taken *en masse* into medicine, so I have sifted the matter tentatively and chosen out the essential phases that should be considered as appropriate to enter the field of medicine.

Before we come quite down upon the subject of this paper, it will be well to spend a few minutes in getting at the historical perspective in the situation. With even a cursory view of the past,

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we will be better able to estimate and appreciate the psychological problem in its modern phases of development.

Psychology has been much in the historical pit. Wundt of Leipzig early promulgated his puristic tenets as the immovable foundation of future steps. He held that psychology was a pure science, and so should not be made applicable, utilitarian or medical. In this cradle were brought up Kraepelin, Muensterberg and others. Kraepelin went into psychiatry, Muensterberg into further development of psychology, and from these standpoints have evolved many interesting ramifications of the psychological tree.

When I was in college Muensterberg was a purist in psychology, and at that time, even upon our modern individualistic attitudes and utilitarian phases, he looked down with an attitude of disgust and exclusionism. But since those days this once puristic science has grown and branched out into what might be called at the present time, a science with a very small part of it pure, with the largest part of it applicable, individualistic, utilitarian, educational, etc. We see, therefore, that up to a short time ago psychology had branched out into the world of wide individual activities. Even the legal profession has not been exempt from attack and a publication of the psychology of its procedures. There are still other fields where psychology has only just stepped in, where before long there will no doubt arise new literature by the volume. I will merely mention one such subject—Dramatic Art.

The ever-growing branches of this tree of psychology, when it widens out very far, should be followed by those interested in medicine, not only that medicine may enlighten psychology, but also that psychology may enlighten medicine. Just here is the most valuable relationship of these two subjects, how shall one enlighten the other?

The sciences in the past have most of them contributed scientific facts, data and principles for the advance and elevation of medicine. They have mostly done this by contributing small particles of their knowledge to the students of medicine. There has, also, been another large way in which the sciences have contributed to medicine; and that is, by having the medical man master the science. In fact, when I was in Berlin in 1910 the loudest cry for research men was not for medical men to do research in medicine, but the

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cry was for medically trained men who were also masters of some other science, to do research in medicine with their science. This, therefore, flavors of an M. D. and a Ph. D. becoming a research man in a medical field. At that time the greatest future that could be opened to anybody was opened to men of such training. The history of medicine has proved this step to be true. Now why is not this to be a beautiful analogy for psychology as a science to follow? Suppose we should take the hint, what would we do? We would have a medical man as a master of another science doing research in medicine along psychological lines. This then we may suppose to be the avenue for the greatest amount of service that psychological science can give to medical science. I fail to see that that science left alone will do it. The other sciences have not except in a partial way. They must be wedded and welded together to accomplish the most serviceable end. The result of this would be the making of such men as Kraepelin, Muensterberg and James. It is more of just this type of man that medicine needs to-day. Medicine surely does not need so much the presence of the normal psychologist taking up medical problems as it does the medical psychologist working on psychological problems. No mere normal psychologist is competent to grasp the problem in medicine as widely as it should be. It is then this other type of individual which the situation most strongly demands. This has been true in the other sciences. The medical men with adjacent science have been long enough in that science to develop a certain type of mentality, and type of research and type of problem investigation which their medical training alone could not have brought them. As far as any definite type is concerned then, what we need out of the psychological field in medicine is simply no more or less than the psychological type of approach. What is this?

The psychological type, what is it? As we recall other types of mentality our mind first fastens upon the legal mind as one type. By legal mind we mean the type of individual who is forced by his education to take the legal attitude toward the world at large. The legal attitude may be considered to be certain mental attitudes, certain mental reactions, certain learned judgments and conclusion-making which the legal tenure of the region posits as its standard. I think it is well recognized that there is such a thing as the legal mind. Then there is also what is termed the student

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mind. This is simply the type of individual which is made by a predominant form of education where one mostly hears, slightly collaborates and writes. This has been very lately established beyond refutation. It is the type of individual known as the hearing, slightly collaborating, writing individual—the student type.

There are also other types of individualism of this sort. There may very well be what could be called the medical mind. This would naturally connote the attitude of the physician which is unique and distinct to him, which other individuals do not possess. Then, too, in a vague way we speak of certain individuals as representing numerous lay types of mind. As a general term, then, a mentality type would refer to certain uniform mental attitudes taken toward a field of work or a field of research.

It is equally true that there is a psychological mind. I mean by this that it is equally true that the psychologist has a certain unique attitude toward the field of his endeavor, an attitude which other individuals do not take, and one which is primarily developed and brought to final perfection and maintained so by a certain definite, restricted and exact line of effort. Just how much work or what work or what education or experience it takes to develop what may be called the psychological mind of any individual, is for me to mention. There are, also, two other points which I wish to establish. One is that there is such a mind, and the other is that it is just this sort of a thing introduced into medicine, which is the essential phase of psychology that is now needed. Perhaps these two points may be clear enough already. I should rather think that they ought to be, but in case they are not yet quite as clear as they should be, let me offer a few other reasons for these tenets. In other words, let me say why a psychological mind exists, how it is made, and why just that is the chief need of medicine.

That the psychological mind exists may be established without analyzing the mind of the psychologist but merely seeing what he does. He is the representative of a separate science; he gathers different facts from other sciences; he gathers his facts in a different way. He has a special laboratory, too, as a means of research. He deposits his findings in a unique literature. This is evidence enough to show that a psychological mind exists.

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True, this is objective evidence. There is also another whole field of evidence into which we need not go now—subjective evidence.

How is the psychological mind made? This is simpler. It is made by doing the work of the psychologist until you get the attitude of the psychologist. The time varies with different individuals perhaps from six months to two years. Some minds can never get it. Experiencing the work of the psychologist makes it.

Why is the psychological mind the chief need of medicine? I mean chief as compared to other contents of psychology—facts, technique, historical knowledge, or the mere intellectual acquaintance with numerous phases, educational, genetic, animal, normal and abnormal. It is the chief need because medicine needs the mental attitude of this new science to take up its problems sympathetically. The medical facts are already waiting to be brought to light by that type of approach, that type of mind. It is this mental approach to medicine we need.

Upon the basis of these statements let us turn now to see what sort of a program would be necessary to meet this end. Before we do this let me freshen in your minds the proposed curricula constructed by the learned men just mentioned who contributed to the symposium. I will present them all before discussing them.

Franz suggests that students should have (p. 911) an elementary knowledge of mental processes; should appreciate the power of the mind for health or illness; be given at least a view of mental conditions, signs and therapeutics, and be prepared to treat many individuals who now seek with success charlatans of all kinds.

Adolf Meyer proposes the following (p. 914) procedure to introduce psychology into medicine. He would add to an outline of the psychology of normal life to the course in physiology, and have it given by the staff in psychopathology; an outline of psychopathology should be added to the course in pathology. Then when psychiatry comes the students will have the fundamental facts and methods as outlined by Watson and Prince.

Southard comes next. While he offers a learned discussion of the problem, he makes no detailed proposal as to change of curriculum. What he says is decidedly worth while and should be read by all those interested in this problem, in order to sense his exquisite point of view.

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Watson outlines his medical course in psychology as follows: First, one year's work of three-hour periods weekly, one hour lecture and two hours laboratory. This should be the minimum of time devoted to psychology in the medical school. The course should focus on vision and hearing with an emphasis on function and use of these two sense organs. Otherwise there should be given the notion and proper setting and control for a psychological experiment, clinical work on Binet-Simon tests, and work on the acquisition and retention of skillful acts. Then study normal process of association, memory and retention. A few lectures and experiments on normal reaction time should be given. The subject of the subconscious should be entirely omitted.

Prince closes the symposium with his proposal. He recommends a study of the subconscious and a list of 20 other subjects. The intention is to supplement the program as proposed by Dr. Watson. The list of subjects follows: Hypnoses, suggestion memory as a process, amnesia, fixed ideas; personality dissociation and syntheses, emotion and feeling as forces, the sentiments, repression, resistance, conflicts, inhibitions, mechanism of thought; complex formation, complexes as determining judgments, attitudes, etc.; association processes and reactions, word and galvanic, habit processes, automatisms, mechanism of dreams; influence of body on mind, fatigue.

This Prince calls a rough outline of what the student should be taught in a pre-medical course reserving their disturbances, which is psychopathology, for the medical school proper.

Thus four of our representative thinkers in medicine and psychology have outlined the course. One can readily see here a touch of bias. Franz advises from his attitude, Meyer sidling toward psychiatry, Southard looking to the teaching phase and pathology, Watson pleading for pure conscious psychology almost solely, and Prince preferring preparedness upon particularly the rarer phases of psychological lore, then piecing it out by adopting Watson's suggestion, yet constantly emphasizing unconscious phases.

Thus it would seem that all these men had been rather prone to be set and confined to their own field, trying, as it were, to implant their own chosen field into the medical curricula with little reference to each other's field or to the still wider field they have not yet touched.

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This all plays for the possibility that a larger plan is possible, a more extensive view is possible, and a still unmentioned service to medicine also awaits us.

Let us turn then to the problem anew, and, with our higher aim of contributing the psychological mind to medicine, let us take over whatever items of these programs seem to fit that aim, add what is lacking, supplement with the new compartments that have of late been opened up in psychology and with this more modern composite, let us see where our data leads us—in the formulation of a modern course of psychology for medical students or, in a word, to find medicine's essential phases in psychology.

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THE AIMS AND MEANING OF PSYCHIATRIC DIAGNOSIS.

By ADOLF MEYER, M. D., Baltimore, Md.

Strangely enough, at a time when all the other branches of medicine have exchanged discussions of classification for intensive work on the facts with which they deal, psychiatry is still considerably wrapped up in considerations as to what its diagnoses should attain.

Fifteen years ago, I opened a discussion of recent problems of psychiatry with the following paragraph:

> Most text-books of psychiatry show plainly an effort at harmonizing one's daily experience with that which one may consider the safe scientific generalization of the age or of the individual. Some writers do it chiefly for didactic purposes, in order to shape the mental attitude of students; others more especially because their experience is continually fermenting in them, and demands an orderly arrangement in order to give them peace and satisfaction. In any such effort we may distinguish those whose tendency goes more in the direction of harmonizing the facts of experience with a "science" which they consider established and having a set form, while others set the facts of experience foremost, and adapt the order of the science to their *needs*. The large number, of course, of those who practice the specialty are on free empirical ground—persons who are more or less professedly, and perhaps with preference, without system, and get along best without taking a definite stand of their own on general questions, and who, if they be teachers, render the general consensus without any special interest one way or another. (Church & Peterson, 4th edition, 1903, p. 650.)

To guide the student—and one's own work—as directly as possible to the facts which really can be studied and worked with and which are the safest expression of the nature and depth of the disorder and of the points of attack for any treatment—this, to my mind, must be the ideal of teacher and practitioner and investigator alike.

On the other hand, any system which aims mainly at the traditional accumulation and enumeration of "symptoms of disease-entities," if it does not bring out the points mentioned above,—*i. e.*, the nature and depth of the disorder, the factors at work and the points of attack for treatment—tends to create entities for mere

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identification and from there on to suggest mainly deductive reasoning. One thinks of the disease in general and not of the facts presented by the patient, and reasons from that more or less abstract something or assumed entity.

There are, to be sure, fields in which the worker must be willing to run a risk, to run ahead of his facts, to shape his aims for what he wants to attain rather than according to the facts at hand. We must have the courage of hypotheses. I do, however, feel that this should be encouraged chiefly among trained workers and where research is stimulated, and not in the systems which are to be the equipment of those who are mainly students or practitioners.

Our facts and our ambitions lie in the *structural* field or in the *functional* field of *description,* and in the fields of *etiological or causal interpretation* and the fields of *prognosis* and of *treatment.* Let us consider the first, *i. e.,* the condition of structure of the nervous system and especially of the cerebrum, and of the sensory-motor equipment and of the vegetative and regulative mechanisms of the body, *i. e.,* the internal secretion organs, the foci of infections, etc. Whatever facts we can get in this *structural* level of observation are undoubtedly most dependable, controllable, and lasting. Sometimes, they *are* a *complete explanation,* where we can reproduce them experimentally, as in beri-beri; or they may be empirically clear enough and safe, as in parenchymatous syphilis or paresis, where we feel sure that the histological findings have precedence over any other form of examination in ultimate dependability; or in the senile processes, although there the principle is not so clear; or in epilepsy, which leads us to still more uncertain ground. Yet many of us feel less certain that we might always be able to mark off paresis from the mesoblastic and less insidiously progressive cerebral syphilis than we did 20 years ago, although the rank and file of the cases still are best judged with the structural concept or lesion type in the center of our thought, as long as the *intra vitam* reactions tally so closely with the histological returns.

Pragmatically, the structural supremacy would be accepted as clearly established where we might declare ourselves willing to trust the study of a sample specimen of tissue taken from the living patient as is done in cancer and of late in the study of the thyroid. Where this test is not considered dependable, we might do well to turn to a functional pathology, either in the form of reactions of

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the body-fluids, or in the form of various functional tests, including glandular, neurocerebral and psychobiological functions.

This second—the functional—field might roughly be divided into the physiopathological and the psychopathological ones, at least if we agree on certain revaluations of these terms, as was done in my article on objective psychobiology in the *Journal of the Am. Med. Assoc.*, September 4, 1915.

In the physiopathological sphere we may distinguish the serum-reactions, in which we really withdraw a sample of the fluid body-tissue for structural or chemical tests or for biological study, as in the complement fixation and Abderhalden reaction and the like; or we may subject certain functions of the organism or of parts either to tests in the way of establishing certain conditions, such as pulse, temperature and respiration curve, the gastrointestinal and secretory and metabolic regulations, or in the way of pharmacological tests as in the study of vagotonia, sympatheticotonia, etc. With all the general progress of late years, the physiological or physiopathological chemical tests have hardly obtained a leading position except in a limited sphere and for the determination of part-disorders, as in the measuring of emotional trends by the blood-sugar and the like. The serum-reactions and biological tests have been more fruitful. The field has, however, hardly been touched in the most promising line, viz., that of experimental-preventive pathology; and the problem of internal secretions unfortunately still is the ground on which an undue amount of speculative guesses obscures the lines of safe and well-controlled work.

The psychopathological field has really the most remarkable strides to record. Since the analytic-synthetic dynamic viewpoints have asserted themselves, the psychopathological problems of man lie before us in a much more humanly comprehensible form. Not only the so-called psychoneuroses or minor psychoses, but also the more bewildering and apparently unintelligible types dissolve themselves to a far-reaching extent into reactions not so foreign to normal human experience. We find not only "method in the madness," but many common links with the normal, where the passing generation vainly sought for exclusive salvation in the urine and fæces, and in the sham comforts of neurologizing tautologies. With critical work on the facts and a little less quibbling over pet theories and a little less vituperation of the contrary-minded, we can to-day show the student and the patient

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material that leads us into the midst of where things happen. Even simple description of the overt and implicit activities of the patient takes us a long way towards an understanding of what is right or wrong in the condition, and towards the third viewpoint of prominence, the *etiological,* that of the *causal and experimental interpretation.*

This is undoubtedly the ground of *real pathology, i. e.,* the ground of real explanation of disease. The chief gain we have to record here is the gain in tolerance of the *multiconditioned character* of all the conditions with which we deal. We always have to reckon with at least two factors, the more or less *specific* causal agent and the constitutional make-up; indeed, merely to mention the latter forces us to accept a multiconditioned experimental equation. We cannot speak of alcoholic insanity except as a general group of a multiplicity of disorders in which alcohol plays its various rôles; we cannot speak of syphilitic and parasyphilitic disease any longer without much more additional qualification; even a simple brain injury or an emotional difficulty must be studied as one of many dynamic factors, and the upshot is the recognition that a purely etiological explanation is either too summary in many of the cases, or it is too complex to be practical.

This is why, ever since Falret and Kahlbaum, the combined descriptive and etiological and structural conceptions have been welded into " clinical entities," entities for bedside use, with varying sagacity and reserve. To-day, the majority stands under the standards of German nosology, and, with the good old tradition, physicians and students sort out the *patients,* not the facts, and label the men and women as cases of " manic-depressive insanity," or " dementia præcox " and a few other entities, created by Kraepelin in a fit of indignation against Ziehen, and praised to the world owing to the prognostic virtues and ultimate simplicity of his nosological schema.

To bring in prognosis as a leading feature in a nosological system is about as wise as to bring the issue of religious denomination into an election. Even the cock-sure attitude about paresis is wavering. We still have reasons to remember Stanley Hall's bright taunt, that those who talk so glibly of dementia præcox should call paresis thanatic or deadly dementia (*Adolescence,* Vol. I, p. 305). I, for one, am determined to subordinate the prognostic verdict to the inquiry into a more constructive question,

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that of the problem of therapeutic modifiability, which in turn is subordinated to the study of the working of all the dynamic factors and the structural and functional descriptive facts. Looking over my experience with this in view corroborates an early impression that few patients have but one abnormal factor working in them. That which is *one big calamity,* one disease, resolves itself usually into groups of facts none of which is *the unique* and unequivocal cause or force "back of it all"; but each combination has its dominant feature and subordinate features open to study, and some of them open to therapeutic readjustment. And since we are far from omniscient, we do well to ask: Will our salvation come from any unitary Kantian *Ding an sich or noumenon,* that which is back of the practical nosological *entity,* apt to be made a starting point for deductions, or from a better grasp on that which we can work on and not merely *think* about?

I do not share the holy horror of the *Ding an sich or noumenon* entertained by some people. It is well that we should have our concepts and words for the totalities even if they never can be fully realized as wholly indisputable entities. For both scientific and practical purposes, is it, however, wisest, as I said at the outset, to choose one's noumena or ideal entities and bedside terms as closely as possible to where one actually can work, to choose them where their help is needed and not to sacrifice our progress to the old notion of unitary one-name "*diseases*" where *many* facts call for consideration. While, in a way, I look for what is back of the surface, that which is back of it all in the sense of being the essential and fundamental fact really answers better to the call: What is there *in* it and what is there *to* it?

Hence, where structure expresses my facts, I bow to structure, and I bend all my energy upon an understanding of the conditions which explain and can—or cannot—modify that structure. If structure is subordinated, the mere necessary *background of the battle,* not well known, or only incidentally affected, I turn to the battling elements.

In order to be able to draw upon all the helpful elements for the understanding and handling of the condition presented by a patient, I force myself first to get my facts concerning the total-reaction or reaction-type or reaction-complex, whether it is organic, or toxic-delirious, or affective, or paranoic, or a benign or a malignant substitutive process, or a constitutional defect or

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perversion, or a mixture. The reaction-complex is *then* qualified by the statement of the etiological or dynamic factors at work; it is next weighed for the possible structural involvement and the therapeutic opportunities, and the prognosis; and, finally, according to whether the case does or does not coincide with a well defined practical type, it is *classed as identical with, or akin to, a standard unit* such as we keep for our statistics and for elementary teaching.

One thing is certain. We have to get away from the idea of "one person one disease." Where would general pathology stand if it had to conform to the reports of the so-called cause of death without qualification? That our own committee on statistical classification should at this late hour have sworn allegiance to the German dogma without provisions for mixed and merely allied types, was a somewhat distressing surprise. Fortunately we still constitute a free country and have reason to hope that if a cause is just it will ultimately find a majority.

DISCUSSION.

DR. ABBOT.—Mr. President, the paper that I expect to read to-night takes up in part the main points which Dr. Meyer raises. I will not now touch on them but will speak of a minor matter. He speaks of not finding the "allied to" categories in the classification of the Committee on Statistics. The phrase "allied to" means that we are not sure of the diagnosis but think the cases probably belong to the classes to which we call them allied. They are really undiagnosed and it seemed better to call them so frankly. Hence, the "allied to" categories were omitted from the report.

DR. MEYER.—Mr. President, I would like to say in reference to Dr. Abbot's explanation that undiagnosticated and over-diagnosticated might perhaps be two classes that he referred to. That at least would characterize quite a number of cases. To speak of the case as undiagnosticated because it contains more factors than the pigeonhole scheme contains would be both disastrous to the attitude and conviction of the physician and ultimately to the welfare of the patient.

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THE PREVENTION OF INSANITY AND DEGENERACY.

By CHARLES W. BURR, M. D.,
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One of the signs of the times, whether for good or for evil, is that the control of many medical matters is passing out of the hands of physicians into those of laymen, or bodies largely made up of laymen. How much this is the result of a much-to-be-deplored indifference on the part of medical men as a class, and to what degree it is a symptom of the very rapidly spreading belief that untrained people are better judges and masters in technical matters than men who have had special training, need not be discussed. It is one of the instances of governmental interference in matters which in earlier times were regarded as under persona control and not an affair of the state. It is one of the results of the wild fury of altruism which has overwhelmed the country, and has produced much unwise legislation, brought about by the public being misled by incompetent newspaper physicians, whilst those most competent to speak hold themselves silent and aloof. It is partly the fault of physicians themselves. The often referred to citizen of Mars, if he were to visit a medical convention to-day, would be astonished to find so little time devoted to such a vital and practical question as how to preserve and improve national health by the prevention of mental disease, while so much time is devoted to the Freudian interpretation of dreams, the relation of the solar myths to the causation of insanity, the cure of hysteria by mental catharsis, and mystical explanations of mental processes. He would be told the authors of papers on these subjects have "vision" and imagination which sees into the heart of things. He might not believe what he was told. Speaking seriously, I do not think that we, the members of this Association, barring our Committee on National Mental Hygiene, have done all that is possible to inform the public what a menace insanity, and degeneracy in general, is to the national health, and to instruct the citizens what

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can and ought to be done to prevent an increase in, and in some degree diminish, the rate of degeneracy. It is the more important for us to take our part in this movement since we can by our knowledge show what things are possible to be done, what things are of value to be done, what things to avoid doing. Also we ought to act as a break on the ill-informed, but enthusiastic who believe that much more can be done than nature will permit, and who in trying to bring perfection accomplish nothing.

I purpose to discuss not only the prevention of insanity in the narrow technical sense of the word, but all types of mental degeneration, because they all, feeble-mindedness, epilepsy, pathological alcoholism, criminalism, hysteria, etc., are more or less closely related and are all of vital importance, and because the same or almost the same means of prevention are valuable in all.

The ideal way to cure an evil is to find out the cause and then remove it. Of the two kinds of causes, predisposing and exciting, the former is the fundamental causative factor. There are many exciting causes of degeneration, several of any one type of degeneration. Moreover, occasions are often mistaken for causes, and in mental disease, symptoms are frequently confused not only with exciting but also with predisposing causes.

I assume that many of us will agree that the cause, the real predisposing cause, of all degeneracy, is a defect in the protoplasm of the victim and that that defect has many exciting causes. I further assume that not a very small number will agree with me that the defect is a result of heredity. This being granted, time is too short to prove it, it becomes our task to see what can be done to lessen the number of marriages (in our innocence we will assume that only the married have children) of people who may, because of their own defects, defects not patent enough to be recognized by people in general, produce defective offspring, and what can be done to prevent the defective offspring themselves from procreating.

To remedy the first of these evils is impossible. We must accept it as a fact, and as irremediable, that the great river of degeneracy is largely fed by springs which, though seemingly pure, are in reality polluted. Cures have been attempted. Certain of the states have passed laws the purpose of which is to prevent marriages of the unhealthy, but they belong to the class which we Americans so

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love to pass, laws impracticable and impossible to enforce. In one state, *e. g.*, the man himself states whether he is an imbecile, and if he says he is not, the clerk of the court cannot go back of the statement. Another requires examinations to be made and tests to be submitted to which, properly done, would cost the applicant for matrimony large sums. Law cannot take cognizance of several of the affections in parents which lead to degeneracy in the children, *viz.*, mattoidism, paranoidism, and eccentricity. The woman who thinks she is a man and the men and women who are antis to science, to healthy religion, and to sane politics are pathological but uncontrollable. One of the worst parents a child can have is one of those sometimes superficially brilliant, always egotistic, eccentrics who are idiosyncratic in morals, manners, and opinions, who never are suspected to be mentally diseased, save by a small number of cranky alienists. Such people are prone to have a strong but perverted moral sense, the dictates of which they follow regardless of consequences thinking they are martyrs for conscience sake. They believe they are logical and are so childish as to imagine that logic is important in life. You all know the type I mean. You see them every day and you know what kind of children they bring forth and how they reinforce the evils of heredity, with which they have burdened their children, by the most vicious kind of home education. Another dangerous type is the somewhat feeble-minded but not wholly imbecilic. Though we can do nothing with these people we can do something with the frankly insane, the epileptic, the imbecile and the pathologically criminal.

First, as to the insane. So far as procreation goes I am not sure they do as much harm as the people alluded to above, because many of them are impotent, many are held in institutions, and many in the intervals between attacks realize fully their duty not to bring forth and act accordingly. Many epileptics and mentally ill people lead heroic lives save when acutely ill. Happily also, laymen are more and more realizing that the insane need treatment in institutions and need to be restrained of their freedom. But unfortunately, even to-day, the diagnosis is often not made until the patient has been ill for some time, has lived without a moral sense for months, and this not infrequently leads to opportunity for impregnation, an opportunity too often embraced. Every year I see as patients young men, more infrequently young women,

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within a few weeks after marriage. They have not, as misogynists declare, been driven insane by the horrors of matrimony, but were insane when they married and their offspring suffer. The only way in any degree to prevent this is by indirect means, by bringing to life again, the dead or dying family physician, who in the old days not only treated the ill but knew the family, was their friend and adviser and was a shrewd observer and noticed when John was getting a little queer, or Mary Ann was too moody and fanciful. I have not idealized him, he really was. The communal district doctor, toward whom we are seemingly drifting, will not fill his place nor do his work. He will be a bureaucrat and just as useful as bureaucrats always are, but the people are determined to be regulated by government even if they die for it. The founders of the republic were, it seems, dreamers who believed government is a necessary evil and the less we have of it the better; thought that men have some power of self-control. Some present dwellers in the land, especially those hailing from much-governed countries, think government is such a good thing we cannot have too much of it, unless, because of the breaking of their chains, they run to sheer anarchy. Others, inarticulate poets, dream away their lives in the fairyland of socialism, or eat their hearts out in a self-created nightmare of suspicion of the thrifty.

The problem of the insane whose disease is recognized, is difficult enough. While they are confined in hospitals there is no danger, but insanity has a bad habit of remitting (it would be much better if it did not), and during these remissions there is grave danger of procreation. A very simple, but wholly impracticable, method to improve the race would be to confine a person for life in a hospital, once he is sent there, but it could not be done and if, with our passion for making and then not enforcing laws, any state enacted such a statute, its citizens would hide patients from the doctors. The difficulty of the problem is shown by the following example. A married woman suffering from manic-depressive insanity is insane two years out of every five. The other three years she is, so far as symptoms go, a mentally normal woman and may be a very useful and intelligent person, but she should never breed children. How can it be prevented? Much as I am opposed to asexualization in general, because of its impracticability, I believe that under circumstances such as given above, it is not

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only justifiable to make the woman sterile, but that not to do so is unjustifiable. What to do with the adolescents during the interval that often occurs between the first attack of adolescent insanity and the inevitable second, I confess I do not know. They cannot be confined. No law prohibiting persons who have ever been insane from marrying can be enforced, because they themselves will not admit their previous illness, often they do not realize its seriousness, and for the state to investigate the whole past life of applicants for a marriage license is impossible. Further many impregnations occur among the unmarried, the rate being higher seemingly in country districts and small towns where professional prostitution does not flourish.

Imbeciles add tremendously, by procreation, to the army of the degenerate. Apart from other reasons against it, I do not think asexualization can be carried out on a large enough scale to have any appreciable effect. To asexualize imbecile girls and then allow them to go free leads to another evil, *viz.*, the increase of sexual disease. Very soon the vicious youths and men of the neighborhood will learn that such a girl is asexualized, and from their point of view safe, their only fear being a possible charge against them of bastardy, and she will soon be infected and thus be a permanent focus of disease. The only solution of the imbecile problem is for the state to undertake the care of all imbeciles in any way dangerous to the state and keep them in institutions, preferably farms, for life. Such farms could be almost self-supporting. Expensive as this would be at first, the ultimate cost would be less than the present method, or rather lack of method, entails because the population of almshouses, prisons and workhouses would be decreased and less money would need to be spent on the detection and punishment of crime.

The problem of the moron, *i. e.*, the highest-grade imbecile, is very difficult because so often his intelligence, his intellectual power, is so high, that, save to the technically trained, his imbecility, *i. e.*, his lack of moral sense, is hidden. He is the more dangerous because he is the connecting link between the insane man who commits a crime and the sane criminal. (I am still old-fashioned enough to think that a sane man may be a criminal.) The moron is always criminal by instinct and commits not only crimes of violence, the only ones his more imbecile brother is capable of com-

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mitting, but also crimes requiring cunning and planning. Whether such a policy can be carried out I know not, but permanent institutional care is the only means by which he can be prevented from injuring the state and the race. He is harder to manage than the low-grade imbecile, who often, because his sexual reflexes have never developed, is rather good-natured and sometimes innocent in conduct. A jail, which really is a workhouse, is the proper place for the moron. But the difficulty would be in making the diagnosis. Suppose a reactionary like myself, who believes in jails and hanging and such brutal things, should be on a commission with an "uplifter," who thinks that everyone may be reformed, how could we come to any agreement either as to diagnosis or treatment? To-day "uplifters" are very often on commissions of all kinds and not rarely in controlling numbers.

The imbecile of middle and high grade is very prone to join the criminal class, and the crime question is closely connected with degeneracy. Though I am not philosophical and logical and up-to-date enough to accept the most recent, and hence necessarily true, dogma that all crime is caused by mental disease, when it is not a defence reaction of a very good and heroic person against the sins of society, I know by personal clinical study that a not small percentage of criminals are mentally diseased or mentally defective, and that many others are so vicious that their offspring will very likely suffer from some form of degeneracy. All such should be kept under confinement for life. But the difficulty is to define the word criminal and to make the diagnosis. A rough, working, not a scientific definition is, a person who habitually lives by breaking the law. Such simplicity will not satisfy the members of the newer schools of sociology and psychology, but we are not considering psychological justice to the criminal but what his influence is on the welfare of the race. We all know that every person serving time in jail is not in essence a criminal even though the charge may be as serious as homicide. It is entirely possible for a man who is really a person of law-abiding instincts (I assume that such instincts are admirable though there seems to be an increasing number of "intellectuals" who think it is only admirable to obey the law when it agrees with your ideas) to be so beside himself with rage as to kill. It is possible for a youth of inherently good stuff to be so tempted as to steal or

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embezzle. Indeed many crimes are done by people who are not criminals. The following case illustrates that an alleged criminal by accident may be the real thing. I was called to examine a young man, because the attempt to prove his crime (theft) was an innocent boy's lark had failed, in the hope I would give the opinion that he was an imbecile. The father, a physician said, in apparent astonishment, he could not understand how a boy of such a good family could have done such a thing. I knew, but he (the father) did not know I knew, that within a month he had told a patient a consultant's fee would be $300, had been given the money to pay the bill, had arranged with the consultant to do an operation for one hundred, had paid him that amount and himself pocketed the difference. This man was of good repute but bad character, a very tricky person, and his son was his biologically to-be-expected offspring. The young man has continued in the course the father continued till death. There are some criminals who never get before a court because their crimes, the things against society which they do, are not crimes but sins. Most unfortunately sins, I mean of course biological not theological sins, always are serious in import, serious in result, no matter how trivial they appear, while crimes may be trifling, or may be entirely artificial like many of those recently invented by Congress and the assemblies of many of the states. For example, it is a crime in Kansas to circulate a newspaper carrying advertisements of cigarettes.

We need some way to make a differential diagnosis between the accidental and the habitual criminal. The psychiatrist can, given time enough, make the diagnosis, but there are not enough psychiatrists to do the work and altogether too many pseudo-psychiatrists who are aching to get the job: some out of altruistic enthusiasm, some because they need money, some because of the notoriety gained by being in public movements. One of the difficulties in all reform movements is to keep out the parasites who see a way to an easy living by pretending to be interested. A pseudo-psychiatrist is one who does not agree with me. There is one type of criminal, however, we all will agree should be confined for life. He starts either as a dull, stupid boy, or precocious, but having no sense of discipline. As a youth he runs wild, commits petty thefts, is cruel toward weaker and younger boys, precocious in sexual knowledge and acts, a liar and without respect for anyone, lazy

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and indolent, doing only casual work, never learning a trade or working at any one thing for any time. He is not the victim of society, he does not usually have a stepmother or a drunken father, he has not often been taken from school too soon. He is protoplasmatically wrong. He is sent to jail and to the house of correction repeatedly. He never commits any crime requiring deep planning. There in another type plausible in manner, often pleasant in bearing, careful of his language save when among his own kind, but a liar, a thief and worse. You see him by the dozen every time the court of Quarter Sessions meets—flashy in dress, dirty in person or much more rarely having an effeminate nicety, plausible in speech trying to hoodwink the judge, shifty in manner, either brutal in face or with a weak girlish, childish prettiness which makes young women amateur social workers, he does not deceive the trained workers, think he must be good and unfortunate, an impression he tries to make stronger by his tale. He also serves many terms in jails. Now these and all habitual criminals are incorrigible. They never will be of any voluntary good to the commonwealth and should be made to work for life. They will only do it by compulsion. The tendency to-day, however, is the opposite of this. The most up-to-date penologists teach that everyone can be saved. One of the means of salvation is the parole system. There are many inmates of prisons who deserve parole but many get a parole, and no law can be made to exclude them, who ought not to be let out. They are given and take opportunity of their parole to procreate their kind. Probably few of the advocates of parole have ever thought of this aspect of the matter. We are strong on eugenics in this country so far as writing about it is concerned, but we are weak when it comes to action. We will neither let nature take its own course, which might be the wiser thing, nor ourselves take the severe course which would cure, or at any rate palliate, some ills. Our soft sentimentalism for the convict makes us forget what evil he may bring to future generations.

One of the objections to the abolition of capital punishment is, murderers if not executed, and execution, even imprisonment, is to say the least rather rare, are often pardoned after a longer or shorter term and procreate their kind. Within the last three months, a murderer released from a Pennsylvania jail two years

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ago, after serving 10 years for the murder of his father, committed a murderous assault on a woman who refused his advances. When one remembers that we have 10,000 homicides a year in this country, we realize the importance of the matter. Under our present laws, murderers acquitted on the ground of insanity are often set free after a longer or shorter stay in a hospital (sometimes they go from the prisoner's dock to freedom) and they too may procreate their kind. It would be better if a person absolved from responsibility on account of insanity should be confined for life in a hospital for the criminal insane. In the wicked days of Victorian England and earlier this was done, but since the British have, in these reforming days, created courts of criminal appeal, they probably will soon admit "brain storms" as a defence and then be as bad off as we are.

I intend to make some adverse criticism of certain things done with popular approval (really they are done without the people paying any attention, for citizens of America as a class fail in political duty, and any small group of people can have passed any law claiming to improve morals, because no politician is brave enough to fight against any movement pretending to be holy) and intended to help both the individual and the race, and since anyone who takes the unpopular side in public movements alleged to be for the betterment of the people, is always supposed, at least alleged, not always in good faith, to be influenced by improper impulses, I wish to state that I am not an employer of labor, nor in any way interested in anyone who is. I am not subsidized by any commercial person or body, neither brewers, distillers or others. If by any chance the reactionary is admitted to be honest then he is accused of narrow-mindedness and ignorance. As to the first I claim I am so exceedingly broadminded that I think and believe the power back of nature has more wisdom than we and knows exactly what it is about in running the universe; as to the second charge I have a very firm opinion which modesty forbids my recording.

First, we have gone mad on education. We assume that the entire juvenile population has mind enough to receive scholastic training and that book learning will decrease crime. Both these assumptions are false. Learning never made a bad man good. Greatness of intellect is less important to a man's mental health

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than good morals. Happiness is less dependent on intellect than on well-controlled (reflexly controlled) healthy emotions. The mass of men have very little pure intellect, power of reasoning, and their intellectual development ceases early in adolescence. They are none the worse men because they are not highly endowed intellectually, nor are they less happy, because there is a good bit of humbug, especially among the "highbrows," about the pleasures of the intellect. Few enjoy the so-called pleasures of the mind. Many mistake the pleasure of feeling they are superior for the pleasure of mental work. It must be very nice to believe you have more mind than other people. We are compelling boys, dwellers in a mental world of two dimensions whom nature has not fitted to be scholars and whom she intended to be manual workers, to go to school till they are 16 years old. We are trying to get them to be dwellers in a mental world of three or even four dimensions. They do not do well at school. They drag along. If they are manly boys, they bear their fate as best they may and go to work as soon as the law allows. If they are of the soft type, the easily moldable, the easily influenced, they grow lazy and indolent and by the time the law allows them to work, the habit of idleness has become so fixed that they will not work and pretty soon join the ranks of the corner loungers. This evil is not so great in the country where the farmer, as yet, is allowed to have his son do odd jobs on the farm, as it is in the cities where there is no such work. Of course, children, should not be allowed to do real work and boys should be taught to read, write and cipher, and, when it can be done, to think, but no boy should be kept at school after 14 years unless he shows mental ability. If he has mental ability he should be given educational opportunity in proportion. Careers should be open to talents even if that very bad man, Napoleon, said it. The one thing boys are not taught in the public schools is to think, and the unconscious effeminizing influence of women teachers on boys over 10 years of age is an evil notwithstanding all the claims made by the believers in the emancipation of women. One of the claims of the proponents of our child labor laws is that boys cannot grow properly if they work before they are 16 years old. The battlefields of Europe to-day prove that men may be not only physically strong, but emotionally well balanced, though they have worked all their lives and had no great amount of schooling. Of course our

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public school system tends to make pacifists and to teach the glories of peace, the beauties of a non-competitive world, but we are coming to a test when the fallacy of sweet reasonableness in real life will be shown and when the best competitor will kill his opponent. The test, I am sure, will show that notwithstanding our educational follies the race has not lost its strength, its bravery, its sense of duty. It takes a long time for a race to degenerate, and the founding races of this country and most of the secondary comers were strong. I am not sure one can say as much for the most recent arrivals.

Second, prohibition is claimed as the great cure for crime, degeneracy and insanity. Statistics are produced to show how tremendously prohibition has decreased social evils. One can prove anything by statistics, so they are of no value and I shall not discuss them, though I could prove by statistics that, since the modern races that have accomplished the most have been drinking, even drunken races, drunkenness is a good thing—a manifest absurdity. The explanation is that these races are inherently superior, and that the only good alcohol did was to be the fool killer and hence rid them of their weaklings. The thought of prohibitionists is that alcohol is the cause of degeneration; the fact is that the craving for alcohol, not its use, is a sign of degeneracy or a symptom of insanity which itself is a disease of bad protoplasm. No healthy youth craves alcohol, no normal young man wants to be a drunkard, nor does he ever become one. But the degenerate youth does crave drink, does not care whether he becomes a drunkard or not and gets a sensation from alcohol that the normal man does not get. Prohibition has never been enforced for any length of time and if it could the degenerate would continue to degenerate. The statistics proving the tremendous improvement in prohibition states are fallacious. The hospital statistics are of no value as proving anything, because what type of insanity is most common in them at any time depends upon what is the most recent scientifically fashionable disease. To-day it is dementia præcox in most institutions and the euphemism "constitutional inferiority" is replacing the brutally frank but correct word, imbecility. When tobacco is claimed to be the cause of insanity, plenty of statistics will be brought forth to prove the claim. The crusade against it, started by King James of not holy

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memory, has been revived and is gaining ground. Coffee's turn will come next.

That drunkenness leads to great evil everyone knows, but the way to deal with it is not by prohibition but by public opinion, which is stronger than any law. The wicked railroads and the other criminal employers of labor have, by refusing to employ drinking men, done and are doing more for temperance than all the laws on the statute books. The real evil of alcoholism is not that it kills its victims, but that they drag down others with them. If its effects could be confined to its victims it would rid the world of useless people and the race would be improved. There is, it is true, one type of degenerate who is made more normal by alcohol and other drugs. I mean that peculiar member of the genus genius who is saner when under the influence of drugs than when sober. Sometimes his work is world important, work that the world much needs. Now such work is so much needed that I am inclined to think men of his kind should somehow or other be encouraged. They are very rare. In the average man the apparent increase in mental power in certain stages of intoxication is a self-delusion.

One of the alcoholics who deserves sympathy is the real periodic drinker. He sometimes is a man of unusual ability; he often is a man of good brain power and morally sound. Prohibition might save him, I do not know. I have not treated enough cases of the genuine disease to draw any conclusions. A few have, after years of struggle recovered; more have only succeeded in decreasing the number of attacks. A very small number, when permanently deprived of alcohol, have suffered from periodic attacks of manic-depressive insanity. But the real periodic drinker is not frequent enough to be the problem in sociology which the common drunkard is.

I have painted a sad, hopeless, pessimistic picture. The only definite thing I have proposed has been the confinement for life of the imbecile, the habitual criminal and certain of the insane, with asexualization of a certain group of the insane. That these things will ever be done, I do not believe, though I have great hope that the state will more and more take over the care of the imbecile and the insane. As to the criminal, the present tendency is more and more away from punishment of any kind, more and more toward regarding him as an unfortunate whom we can by

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moral suasion and kindness and sweetness make into a good citizen. Worse than this the average citizen is taking no interest in the crime question and when he happens to be on a jury, a duty he too often tries with all his power to avoid, the verdict is oftener the result of his emotional reflex than of any reasoning. The worst result of our attitude toward crime and the criminal is that the rising generation is unconsciously learning to regard crime not with horror but with a sympathy which sometimes leads to evil acts. Cannot then something be done to improve things and to decrease the percentage rate of degeneracy? Much can be done, not by the panacea of passing laws but by stiffening the moral backbone of the people.

The greatest factor for evil is that we have been living in a dreamland for years. The tremendous wealth of the country and its freedom, or rather apparent freedom, from external dangers, have made life easy. The internal evils and their causes only a few pessimists and optimists have seen, and the latter though seeing have not perceived. The loss among many people, especially those who above all need it, of any religious feeling, fostered by the common democratic belief that everyone is competent to have an opinion about everything and lead his life accordingly, has produced much evil and no good. Only philosophers, and not all of them, are competent to have private views on religious matters and the wise ones among them keep very quiet about it.

We have set aside the old view that men should be praised and honored because they have surpassed their fellows in accomplishment and have put in its place the theory of the monkey parliament. We have carried this so far that even in the schools, boys must not have personal rank lest Tom be hurt because Dick is at the head of the class. Therefore, we will not have any number one boy. Our whole school system instead of being arranged that the boy with intellect may get the best possible education, is so arranged that any boy above the imbecile class may pass from grade to grade. The bright boy does not have a fair show. Fortunately he can educate himself. In our colleges boys are wisely not permitted to choose what courses in physical exercise they shall take, but, on account of the pernicious elective system, which fortunately is going out, they are unwisely permitted to study what they like, so that while formerly a college degree

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meant a definite thing, to-day it means only that a boy has passed so many years in such and such a college. Fortunately the colleges do still, in the good old-fashioned way, give the boys four years of time to develop, for the newer subjects taught, especially the politico-sociological courses, which are very great favorites with the boys who cannot study Latin, Greek and mathematics, chemistry and physics, require no mind to learn and do not interfere with the natural mental growth. Democracy has gone so far into license that children must not show respect to their elders even by using the harmless and formerly thought-to-be polite word "Sir." Politeness indicates subserviency.

The things we need to remedy our ills are intangible, imponderable. When children are taught obedience, truthfulness, industry, and a desire to excel, when men realize they owe a duty to the state, when there exists a contempt for weakness and a love of strength, when the symptoms of degeneracy create disgust and not a sympathy turning into love, when the man of strength and mental power, and not the blatherskite, is respected by the people and accepted as their leader, when we cease to be influenced by parlor sociologists and idealistic dreamers, when we realize the inequality of men and accept the rule of the strong, then degeneration will no longer be on the increase but fall back to its proper place.

We are on the verge of a great struggle which with all its horrors has yet its good aspect. We will emerge from it stronger, wiser, better. War is not a favorable soil for the increase of degenerates. It kills many of the best men, but it also destroys much foolish philosophy. It makes people keep their feet on solid earth.

DISCUSSION.

THE PRESIDENT.—Dr. Burr's exceedingly interesting paper is now before you for discussion; it covers a very interesting topic and I trust members will not fail to add something to the subject in the way of discussion.

DR. WHITE.—Mr. President, I would like to acknowledge publicly that I belong, in accordance with the definition of the speaker, to a group of pseudo-psychiatrists and that, because I do not agree with him. I should be very sorry to agree with a program that was so statically concrete and so filled with repressive measures. I listened with a great deal of interest to a previous paper that was dynamic and fluid, and then we come to the anti-climax of the whole situation and a lot of static propositions. I think it would be too bad to go away from this meeting without antagonizing some of these propositions, for I believe we make a great mistake when we lay at the door of heredity so many things; to say that so many irregularities are

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explained by differences in the germ plasm; all this is nothing more nor less than building up a program of doing-nothingness. If you cannot change the germ plasm it is all over. We know perfectly well that some actual conditions of misconduct have been traced to social and environmental circumstances that could be remedied, and if we approached those problems with the idea that they were grounded in the individual and not curable we would be destroying absolutely any possibility of any viewpoint and I think it was a speaker this morning who said "Without vision the people perish." Then with respect to shutting everybody up for life that some psychiatrist may believe to be imbecile. I never heard that before but once, and it was said then by a police official. Now, it does not seem to me that it is worthy of this Association to stand sponsor for it. Dr. Fernald would tell you if he was here that 50 per cent of his feeble-minded boys go out into the world and lead lives of useful citizens in a limited simple sort of a way and do not procreate their kind, and they do not do this for very well recognized psychological reasons which I could mention, but it is not worth while now; but most of those feeble-minded children are defective in their biological equipment that would lead in those directions, and many of them are sufficiently intelligent to realize their defect and they know enough of their responsibility to the herd not to want to procreate. And so without wanting to go into the details of the question I cannot let it pass without opposing the proposition to imprison these people for life; to cut off this class of people who are leading useful lives even though they do not turn out to be the individuals at the head of the procession.

DR. SOUTHARD.—Mr. President. I always rise to speak when I find that I can agree with Dr. White, and that is the reason why I rise at this time. I agree with him in the statements he has made in opposition to the paper read by Dr. Burr in part; but I am sorry that he did not talk about the prohibition element which seems to be stirring at this time and concerning which I had hoped he would say a word. Dr. Mitchell would be more competent than I to discuss that matter, especially concerning experiences in Maine.

Another matter that touches me very closely is this question of mob psychology brought up by Dr. Burr. Dr. Burr says people have very little intellect. After all, he may be speaking about the Philadelphia standard. Of course, in Boston, we count ourselves as having some intellect, although I like to recall that my mother once said to me "Boy, average people are so much below the average!" But for my part I feel that the average people have average intellects and I wonder whether it does much good to make such alarmist statements as those of Dr. Burr about mob psychology.

THE PRESIDENT.—I know Dr. Southard does not make rash statements and as he has mentioned that Dr. Mitchell is better qualified than himself to speak on certain features of Dr. Burr's paper, I will ask Dr. Mitchell to speak on that point mentioned by Dr. Southard.

DR. MITCHELL.—I have listened with careful interest to Dr. Burr's opinions and my personal views concerning the influence of factors other

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than alcohol in the development of chronic alcoholism are in substantial accord with Dr. Burr's conclusions. Alcohol certainly weeds out the persons of unstable mentality with deadly certainty, as anyone who has studied the life histories of persons suffering from the alcoholic psychoses will testify. But such a review will not justify the assertion that a high percentage of these patients would have become insane whether or not they developed the liquor habit, nor can I adopt the fatalistic belief that the chronic inebriate must necessarily have failed in his social relations regardless of whether or not he became a drunkard. While the failure of a natural endowment may be emphasized by intemperance and a breakdown hastened by this cause, it is certain that many inebriates who become social wrecks would not have failed were it not for the use of alcohol. Every restoration from the effects of chronic alcoholism emphasizes the accuracy of this statement. The percentage of restoration is unfortunately low, but not by any means negligible. It would undoubtedly be much higher were it not for the social customs which confront with constant menace every person seeking to avoid the consequences of the liquor habit. Every inebriate must seek his restoration through the life-long practice of total abstinence. Against this course the individual is confronted by constant suggestion, if not pressure of association. The saloon, the pocket-peddler, the customs of the day and the influence of associates are practically united in an effort to break the will power congenitally deficient and further weakened by the habit. Society, thus by its stamp of approval on a useless custom, to speak most charitably, acts to inaugurate a habit which is surely to cause the downfall of many thus starting to follow social customs, and then operates to remove almost every opportunity for relief. At some time in the far future I believe thinking persons will appreciate that social tippling is the breeding ground for inebriety and its consequences and that there will be less general approval of a custom that not only weeds out the defective, as suggested by Dr. Burr, but also causes countless failures in persons who otherwise would have completed useful lives.

Dr. Meyer.—Mr. President, I would like to say just one word on a subject that I think has been misleadingly treated in the paper read by Dr. Burr —I refer to education. Dr. Burr may think that because he has been giving us old-fashioned notions, he may not be as wild as some of those whom he criticizes, but I think he has given us an example of confusing wildness of recommendations. The rank and file of cases do not merit the treatment he would suggest for them, and if he thinks that it is possible to advance his cause by recommending wholesale requirements which will never be taken up by legislatures and which no country can carry through—I mean the locking up of all the individuals whom he should study and help but not merely lock up—and if he thinks that he is advancing the cause by his demands, he is very much mistaken. It is by that sort of wholesale reiterations of impossible recommendations which cannot be carried out that progress is retarded. I should hope that by and by extravagant statements will drop away and a moderate and more constructive program will be put forth.

Dr. Burr spoke briefly in reply.

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A STUDY OF SELF-ACCUSATION

By EARL D. BOND, M. D., Philadelphia, Pa.

In choosing the topic self-accusation, I have had in mind, on the one hand, certain limitations of some students of psychiatry, and on the other, certain characteristics of the symptom itself.

There are some physicians engaged daily in the treatment of mental diseases who are slow to make up their minds. They are open to the winds of opposing arguments—interested, for example, in much of what they read about effects of disturbed internal secretions and at the same time ready to listen to Dr. Gould as he describes the results of eye strain. It is exasperatingly true that much of the time they are left without a ready formed conviction with regard to the particular issue. They claim that their convictions come only with unforced testimony from unselected material. To such minds this paper is offered in the belief that nothing in it will force them to leave their advantageous positions in the middle of the road.

The symptom self-accusation is deep enough because it at once raises the question of self against self, of a part of the personality repugnant to the total personality. It is common enough without being too common; it tends to occur in accessible patients; and for these reasons it is a manageable symptom. And it is accessible to the normal mind.

In every day life we see men of high achievement reproaching themselves for the lowness of the mark which they have hit. Periodically we see women who have done more than their share of work blaming themselves for lack of strength to do more. Arnold Bennett says of Rachel[1]: "She had the impartial logic of the self-accuser. At intervals the self-accuser was put to flight, only to return stealthily and irresistibly. . . . . The self-accuser and self-depreciator grew so strong in her that Louis' conduct soon became unexceptional—save for a minor point, concerning the theft of five hundred pounds from an old lady . . . . She, Rachel, was an over-righteous prig . . . . a blundering fool . . . . Then the tide of judgment would sweep back and Rachel was the innocent martyr and Louis, the villain."

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In Sunday life the feeling of guilt has greater sway: in the confessional, where many unsinned sins are related, and in the hymnal. We sing:

> "Weary of earth and laden with my sin,
> I look at heaven and long to enter in,
> But there no evil thing may find a home—"
>
> "Lord, I am guilty, I am vile—"
>
> "I would not live alway thus fettered with sin
> Temptation without and corruption within."

It has been a pleasure to find that the best descriptions of the twilight zone between psychological and psychiatrical data, with reference to general self-accusation, have been written by two of my friends.

Wells [8] has searched the fields of normal and abnormal life for types of "mental regression," a replacement of fundamental trends by those less fundamental, more childish, less demanding. The most important of the pleasure giving trends which depend on the body and which have little value to real life is masturbation. If the accompanying imagery is of real persons there is some feeling of guilt. Wells covers the hymnal in bringing out regression as a pervading factor in religion; he says that at the time the hymns were written greater sex suppressions gave rise to auto-erotic tendencies with which topics of morbid self-accusation are generally loaded. There is none of this in the less civilized writers of the psalms, who do show however both self-abasement and self-depreciation. And from another point of view the subject covers his instinct for abasement by a fancy that he is wicked. And again, "self-accusation rationalizes a need for help . . . . The prayer for help must often fail. Then the preservation of faith is made easier by the self-accusation of great wickedness . . . . Not because there is no God—but because I am unworthy."

Southard's [8] "Application of Grammatical Categories" gives us the term "reflexive" for certain states of self-accusation. His articles on "Manifest Delusions" give us James' distinction of the spiritual ego and the material *me*. The *I* and the *me* in the normal person are well adjusted: "I am at peace with myself." In the patient the *I* may dominate actively the *me*—flagellation, certain delusions of grandeur. Or the *I* can passively be lost in the *me*—

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inadequacy. It is doubtful to my mind whether in self-accusation the *me* overcomes the *ego* or whether a *me,* remaining unchanged as far as outside observation goes, and according to the patient's own normal judgment later, is misconceived by a faulty *ego.* Certainly a grammatical classification of both self-accusation and the sex activities which it is said to follow as in the reflexive voice is stimulating.

In mental diseases self-accusation appears tied up with many other important symptoms—with delusions of reference, persecution, with auditory hallucinations. Its projections are probably numerous. At present I wish to search several writers and a group of clinical records for information upon the limited topic—direct accusation of wrong-doing brought by patients against themselves. This of course leaves self-abasement on one side.

FRENCH WRITERS.

The French[4] have dignified this symptom by placing it in the names of some of their types of mental disorders. In subgroups under constitutional psychopaths we find "paranoid auto-accusers" and "original systematized delusions of auto-accusation." Dercum[5] gives a similar group. We find Arnaud explaining that the remembrance of his past state contrasted to the present makes a patient pessimistic, and this pessimism increases as he compares himself with those about him. A disturbance of the organic sensations is the origin of melancholia—self-accusation is always a secondary symptom. The real self-accusation of the melancholiac is monotonous, a litany. The false self-accusation of the paranoiac is changeable. Self-accusation tends to religious or sexual subjects.

WERNICKE.

Wernicke[6] wishes us to imagine a disease of the auto-psyche which is to be thought of as having a local habitation in the brain. One of its results may be a feeling of unhappiness, which then determines the content of hallucinations and delusions, in both of which self-reproach may be present. Strong emotion has the power to divert the stream of thought from its ordinary channels, and to form new ones under the influence of an over-valued idea—whose usual antagonist is abolished. There is established a heightened susceptibility for certain stimuli, a partial intra-psychic

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hypermetamorphosis. On account of certain breaks of physical continuity there is no way for the delusion of self-reproach to be connected to higher-idea combinations. The delusion cannot be brought to the seat of judgment, which may be able to deal adequately with ideas which come from another direction. Self-reproach, as well as other auto-psychic symptoms, tends to occur in the milder stages of the disease process.

Adding a bit of William James, we may speculate in this manner: we weep because of some physical process; we are sad because we weep; we are self-accusatory because we are sad.

KRAEPELIN.

Kraepelin[1] says that of all depressive delusions those of sin are the nearest to the ideas of ordinary life. He finds self-reproach fastened both upon very harmless past experiences and upon the progressive events of the present illness. He speaks of the content as being frequently religious, but he does not mention sexual content. The experiences of life which can be considered without involving the emotions, may give rise to mistakes but not to delusions. Strong emotional tone will give an idea preponderating weight in consciousness.

Straight to the point is his consideration of the strain which highly organized society puts upon the individual. A feeling of constant and definite responsibility is the determining factor of self-reproach in a psychosis. Delusions of sin and ideas of self-reproach are not known in people who have simple surroundings. Kraepelin, from his own observations, speaks of their absence in the native Javanese. The point has been strongly reinforced by the fact that in happy-go-lucky negro communities, with lax moral standards, melancholias and especially delusions of sin are extremely rare."

FREUD.

The consciousness of guilt is in every case a product of repression. An idea is repressed only when an instinct is inhibited by coming into conflict with other ideas of higher value to the individual. So at maturity when the memory of earlier sexual acts becomes painful, memory plus reproach is thrown below consciousness and replaced by shame and scrupulousness—successful de-

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fence symptoms. Obsessive ideas are transformed reproaches escaped from this repression; they are always connected with some pleasurably accomplished sexual act of childhood; the consciousness of guilt can be traced almost always to auto-eroticism. Often the repressed material secures symbolical expression.

In this view the feeling of guilt represents not merely an atonement for past wrong-doing, but also the satisfaction of an instinct denied its expression in reality. When the intensity of a self-reproach far outstrips the apparent occasion, this is not because the affect is too strong but because the affect has broken away from some unconscious content and fastened itself to some unimportant thing in the foreground of consciousness."[10] [11]

The conception may be modified by Jung's substitution of "the transgression of an inalienable life-demand" for "auto-eroticism." Or with Adler[12] it may be preferred to regard self-reproach as neurotic conduct for the purpose of enhancing the feeling of self-esteem, of torturing others through self-torture.

The shortness of these summaries is sufficient acknowledgment of their inadequacy, but we are able to take from them certain guiding questions to apply to clinical material. Is self-accusation the result of an effort to explain a sadness that has fallen upon a patient, or to explain away the instinct for self-abasement? Does emotion set up an overvalued idea which then determines self-reproach? Can the feeling of guilt be regarded as a present and continuing satisfaction of an instinct denied its expression in reality? What is the manifest content of delusions of self-reproach? In what personalities do such delusions develop?

With these questions in mind I turn to the present small series of cases to determine what work can be done on a broader series of consecutive hospital admissions to deepen our understanding of self-accusation as it appears in the individual patient.

To-day I present 80 consecutive admissions to the Woman's Department of the Pennsylvania Hospital, beginning with the first day of the hospital year, 1915. We have a two-year view of the psychoses. The records follow the history given and the patient; they do not lead; they do not emphasize. I realize their defects. But for the purposes of this paper I am glad to say that they seem broad, fair and superficial. Why the latter term should have a bad connotation I do not see; the superficial and direct

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should have at least an equal place with the deep and devious. Certainly the inner parts of our bodies are important because they are so closely linked with its surface. I am willing to have this paper classed as another "elaboration of the obvious."

Of the 80 cases, 13 showed repeated self-accusation and four others showed it in isolated instances. There were more than this total of cases showing depression without self-accusation.

As I abstract only what on the surface directly bears upon self-accusation in the 13 cases, the following facts will give some orientation with regard to the series. Insanity appears in near relatives in all but three (B M K). The first five cases had no hallucinations; the next four (F G H I) had many. Both groups, however, were clear and approachable, with remarkable insight into the psychoses of other patients. The last four cases had hallucinations also, but could not turn away from them to talk to the examiner; they were confused.

As to diagnosis the more these cases are studied the less easily they can be made to fit into pigeon holes. The psychoses are clearly uninfluenced by mental inferiority or organic brain disease, although one patient is 73 and another has a hemiplegia. Six of the cases (B C E F G H) at least are classifiable as manic-depressive. Details follow:

Mrs. A, admitted at 42, and remained in the hospital for three years without important change.

A sensitive, very conscientious, bright woman of high ideals, a very competent trained nurse, but rather inadequate outside of her own work. She made devoted friends. Discoloration of the skin of her face coming on at 14 has made her envious and kept her indoors in the summer time. She was devoted to her father, who died when she was a child, and did not get on well with her mother, who later became insane. About nine months before the patient entered the hospital, her mother became ill and an elderly patient, to whom she was devoted and whose ideals she considered high, died. Some one wondered where the dead man's nail file had gone to. Mrs. A wondered if they thought she took it. A man to whom she had been half engaged suddenly came to her and urged her into a hasty marriage; they separated in a week. Here the patient says: "I ought to have helped my sister—I should have had love and I didn't—None of my family is fit to live—My mistake was in getting married—I thought I was to be cock of the walk—I invited him on."

Who is to blame?

"My husband."

Any one else?

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"Myself. I've done it now—I've ruined the whole family—I should have made a home for my mother."

Mrs. B, admitted at 73, and remained three years without important change.

A pleasant, loving, humorous, social woman. Intelligent, a talker, industrious, very much interested in her church work. This person had a first attack at the menopause, with a recovery in several weeks. At this time she said she was unworthy and had lost her soul. A second attack, with recovery, occurred at 62, after her husband had had business trouble and physical illness. Present attack came on suddenly a week before admission, when the patient was recovering from the grippe, and had been worrying for about a year over anonymous threats which came to her husband. The patient describes the onset: "When I went to bed I prayed and said—'Deliver us from evil.' The word evil seemed to stick in my mind. When I got up in the morning to go into the next room, it dawned on me suddenly that I was sick. When I went to bed I prayed the Lord to deliver me from evil and I woke up filled with it—I am damned forever—I haven't the feelings of a human being any more—There is nothing to control my actions and that makes me intensely wicked."

Miss C, admitted at 38, and remained two years without important change.

Bright, proud, selfish, overbearing person, successful as a trained nurse. This patient at 23 had a mild depression. At 30, she had an unhappy love affair. About a year before admission, when worried about her father's illness, she again became depressed. She said she had committed the unpardonable sin, had not lived right, had been unjust to people, and was going to hell, being possessed by an evil spirit. Here during the first few months she said: "Something has happened to bring my mind into the wrong way of thinking—The trouble is I didn't control myself when I could and now I can't . . . . It isn't sickness—it's wickedness—I've been thinking wrong and acting wrong." She refers to self-abuse. "I know that affects the mind—I am under a cloud—I blame nobody but myself . . . . Satan got hold of me . . . . I can't forgive them for bringing me here—It's all my fault being here—How I have been self-centred all my life . . . . The acute thing has quieted down and left me with this terrible belief—I think I must be insane—the possession of my soul and body by the devil—I can't grasp this thing of my being here—I have lost my identity. Doctor—I can't see my way out of this because I am working with Satan and I am determined to have it that way—Something has passed over me—for instance, a marriage ceremony after it is over it is lasting—so this thought has conquered me. Nobody knows the working of a patient's mind—I didn't fight against—no matter what I do—now I belong to Satan. It seems like I am just determined to go to perdition—You know what made my mind go over to the wrong side—it was that terrible sin I told you about." A year after entrance she said: "I am a moral imbecile—It was a terrible crime, but I don't deserve this punishment—There was trickery and underhandedness and cruelty that brought me in here." From this time on the

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patient became much more egotistical, irritable and complaining, while her self-accusation became less marked.

Mrs. D, admitted at 58, in hospital two weeks, recovered in six weeks.

A quiet, shy, religious woman, frail but seldom ill. A year before admission she began to say that she had sinned against God and threatened suicide. Her sister was in a similar state. Her mother, at the menopause, had accused herself of the "unpardonable sin." Here she said: "I felt a band across my head—Then I cursed God—Something left me—my heart and eyes changed. The Bible says I should be single—this is perhaps the unpardonable sin .. . . . One Sunday I took a ride in the new motor instead of going to church—that is the unpardonable sin."

Mrs. E, admitted at 44, discharged three months later, improved.

A bright, normal and happy child. A leader in social activities. After marriage, at 22, and the birth of her premature child, who did not live, she was depressed and self-accusatory. Two years before admission she had a growth removed from her jaw, and since that time she has worried over the question of its malignancy. A year before admission she attended revival services. Three months before admission she suddenly became depressed, refused to eat enough food, and later accused herself of the "unpardonable sin." This sin was something that happened in her childhood. Here she said: "I felt abandoned—as if the world were on top of me—I tried to think and thought what it might have been—I never blasphemed or anything like that—The awful thing came over me and that's all I know." (You were sick before?) "That's where I got the idea I was cursed because I had such awful luck." (You were well for years.) "Yes, but as I look back I see I should have done things better . . . . It was in the first 20 years in my life that I offended God so unpardonably—I was too ungrateful to my father and mother, proud, unkind to my grandmother, one time when she had a headache . . . . My unpardonable sin was my selfishness, indifference and pride, in the years before my marriage—I don't know whether I know what it was or not—I never did things, though it was not what I have done, but my disposition—always discontented."

Mrs. F, admitted at 59, recovery in three months.

A social woman, capable at business, fond of outdoors. She was depressed, restless, but not self-accusatory at the menopause at 43. Nine months before admission she again became despondent, after the death of her husband after a long illness. At first she wanted to die and feared poverty—then she became self-reproachful. Here: "I'm worrying about the way I've been living—dishonest and I can't help it—I've led a bad life—I never murdered anyone . . . . I'm wicked and I shouldn't eat—I hear voices all the time." (What do they say?) "I done wrong because I tried to take my life—I didn't go to church—I got wicked—I sinned and I can't get away from it . . . . I never murdered—I have a clear conscience for that." Two months after admission: "I begin to think I imagined all this—that I done wrong."

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Mrs. G, admitted at 42, discharged much improved in a month.

A moody, seclusive and quick-tempered woman. Previous depressions occurred at 30 and at 33. Thirteen months ago, at the time of her mother's death, she had several uterine hæmorrhages (carcinoma) and greatly increased sexual desires. She lost interest in her surroundings, had delusions of unreality and persecution. Here she said: "I feel I am really the cause of my son's trouble (insanity). I blame myself for everything—this is the third time I've been out of my mind and I'm afraid it is my own doing."

Mrs. H, admitted at 53, and remained for three years unchanged.

A bright, amiable, talented woman, interested in current events. At 39, she had an attack of depression and self-accusation. At 50, she had a paralytic stroke, which has left her with a left hemiplegia. Eight months before admission, the menopause was completed. Two years before admission she became self-accusatory—said she was bad and had had evil thoughts; that she was different from her sisters, and was pregnant by the devil. She also said her son was bad sexually. On admission here: "My mind isn't under control and I keep wishing things—that my boy should go blind and I really don't want him to go blind. I think I have cursed people—things I have wished on my family have come true—I think the worst thing is when I dream." (Are you responsible for the dreams?) "I am pretty responsible I think . . . . There was some noise last night and I was the cause of it—about my boy—The man in the cellar will get him and take him to the mines . . . . I have been hearing voices to-day—I guess I am a wicked woman—I had a boy and never did take care of him . . . . It's sin with me—it isn't sickness—I put my son in hell, the younger part of him is in hell—I got so wicked and thought that the devil overtook me and put me in this hell—The trouble was I dwelt too much on my boy—I ordered the most cruel things for him . . . . I have sinned that awful sin—putting him in the bad place—Thomas—the younger part of him—I made the instruments years ago—I think I am the woman mentioned in the Bible . . . . Such an imagination, a wicked one, but it isn't a crazy imagination—I ordered the boy's eyes to be put out and his heart torn out—I ordered thick spikes for his hands and nails—for his feet—I saw smoke coming out of his eyes—It isn't imagination because it lasted too long." Three months after admission: "The younger part of him is in hell, the child part—If I had been a high-minded thinker, I should never have gotten into this state—I have been the greatest criminal on earth." (What do you mean by the younger part of him?) "The younger years—he was made up of different ages." (Do you mean you sent some part of him to hell?) "His whole body." (How old was he?) "About eight." (How old is he now?) "Twenty." (And well?) "Yes." (Doesn't it seem hard to explain?) "No—only the younger years are in hell." (How could you send anybody to hell?) "Because I was cursed." Six months after admission: "A little wren in the yard represents Thomas when he was small—A larger bird that croaks represents Thomas older—that seems ridiculous." Nine months

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after admission: "I am the cause of all the evil in the world, all the smallpox and all the grippe, all the war going on in Europe and Mexico. I was cursed by my mother before I was born." Two years after admission: "I have done no wrong act, but simply thought wrong things—I was never wicked but may have done bad things through ignorance." She speaks of some apparently trifling sexual irregularities as a child. (Nurses Notes): Everything reminds her of Thomas and her sins. Things such as, good people, screaking doors, whistles. Words such as, mosquito, varnish, desert, sea and cook-book. She says it would be a great comfort if she could realize that she was insane and not wicked.

Miss I, admitted at 48, and two years later, after several marked improvements, a patient in another hospital, not improved.

Even, kind, good in her disposition, rather religious, a hard worker, with few amusements. Health normal. Bright as a child; unselfish, affectionate, making many friends. At 19 had unhappy love affair. A capable trained nurse. For four years before admission had given up work to take care of mother. A year before admission, a change in disposition was noticed, with the beginning of the menopause. She became depressed, indifferent and suspicious. Two weeks before admission she claimed that she had been poisoned and accused herself and a doctor of immoral conduct. At this hospital she said: "I wanted to take care of my poor old mother, but I complained—it's the work God gave me to do. Another thing I did, a terrible sin, I am ashamed to tell you." She refers to self-abuse. "There is something worse—that awful day with the doctor—I am not sure whether I went wrong or not—it was a sin anyhow. There's other sins—so many. I was raised a Catholic and I denied it. Another thing I had a dear, little niece—Was her death my fault? Did I give her medicine too many times? I took her to school, but I didn't know she would get diphtheria. My sin was to complain. Then long ago—with that doctor and that other man—I got rid of him, before it got so bad." Two months later: "I was sinful but God forgave me." Hallucinations become prominent. Under the shower bath she sang: "This will wash my sins away." In another month her behavior became normal. She went home, but began to confess her sins; saw a baby pushed down from the clouds, and connects this incidence with her relations to the doctor. During the next year appeared many fantastic, nihilistic and persecutory delusions, with an hallucinosis combining all five senses. At present she is having many delusions of a sexual and religious character, is self-accusatory, talks vaguely about God and her lover and her approaching marriage, to one or both of them.

Mrs. J, admitted at 38, and two years later unimproved.

A nervous, sensitive, rather ignorant woman. She is described by some as not generally sociable, but her husband describes her as jolly and a hard worker. Four months before admission a baby was born, and for six weeks everything went well. She then began to utter hypochondriacal ideas. Apparently she hadn't wanted this child. Her husband was alcoholic. Here

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she complained first of having tuberculosis of the stomach, and later of having syphilis. She admitted self-abuse. She said: "Me head is not bad—me heart is bad—The stomach pains too. A man boarded with me and he had a bad disease—Oh—how did I get it in my stomach—Who gave it to me? I am damned—I am all to blame—I never done no crimes—They're going to murder me—I have sinned but what have I done . . . . I was blackguarded—I was a whore—It's nice to have life, but I wish I was a little bird so I could walk around and see things—That bad disease I had took out all my brains. You aren't a doctor, but God's son . . . . The soul of sinners never dies—My daughter is hanging on a tree out there and animals are jumping for her—All my life I have been bad—I didn't know about it myself though—I tried everything—the fault was mine—I have been bad." (Why?) "I don't know—it wasn't my fault." (Are you married?) "Yes—I was." (Why do you say was?) "Oh—he's married now to that pretty girl." (Are you married?) "No." (Why do you say that?) "Yes—but I have no husband—I want to stay here all my life. I don't care about the baby—she was the means of breaking my health." Two months later: (Why are you sick?) "A lot of worriment and work and a run-down condition." Six months after admission: "Well—I don't know if I spoiled my life—I never had the proper sense to guard my own church—the church is your body—Joe had knowledge—he didn't teach me—He ate the same food that I ate—it didn't harm him." (Have your sins been greater?) "Yes—I think he was capable of turning things—His stomach was a fertilizer—He was guarded by spiritual guidance." (Do you mean voices?) "I don't know them until I eat biscuits—Their source is inside of me." (Nurses Notes): Patient accuses the nurses of putting something inside of her, which she is being blamed for and that is why she is being punished. Nurses do this at night when she is sleeping.

Miss K, admitted at 42, and died in one month.

A social, kind, self-sacrificing, considerate woman, who had occasional "blue spells." Fond of music, an inveterate reader, sewer and church worker. Tendency always was to work too hard and eat too little. She had always been able to take care of herself until 18 months before admission, when she told her family that there were snakes crawling about her bed; that she had committed the "unpardonable sin," which was self-abuse; that dogs, cats and snakes were inside of her. In her month's stay at the hospital these delusions were repeated. In addition voices told her not to eat; she saw faces in the food and heads on the bed, and she felt it would harm her sister if she took the food. Here she said: "There's a serpent in my stomach and if I don't eat it will not live—The food is part of my people." She did not want to walk over a clean rug, saying that things would drop from her and make it unclean. Many times she hunted for things that she felt on her clothes, snakes and bugs; thought the devil and snakes were in the bed, and wires and bugs. Many times patient tossed on her bed and repeated over and over—"Sinner—sinner."

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Mrs. L, admitted at 50, discharged much improved in four months and recovered in six months.

Her disposition was described as good, jolly, sociable. She enjoyed talking and was excitable; was fond of painting and music. She was a good student, graduating from high school and then teaching for 10 years. She was married at 27, to a man who indulged considerably in alcohol. She had one son. One year before admission she passed the menopause. Seven months before admission she was confined to her bed with kidney and heart trouble. She lost appetite and sleep; became suspicious and feared that she was going insane. Physical examination at this hospital showed a very irregular heart, a strongly positive Wassermann of the blood, and a spinal fluid negative to all tests. Absolutely disoriented—thinking she saw dogs coming to eat her. "I am unclean—I am the incarnate fiend—let everyone hear. Now I am guilty of the one, but not of the other—I cannot live if I don't confess my faults . . . . I think I wronged him terribly . . . . I will acknowledge to the world—I didn't know I had the bad disease till I saw my knee was red . . . . Of all the things I have been accused of to-day—Murder . . . . I don't know what else." Listening to the noises of other patients. "They said I stole things . . . . Did I ever do wrong? She says I stole."

Miss M, admitted at 32. At the end of one year she showed great improvement, followed by a relapse, and at present is in the hospital, unimproved.

An average, healthy child, who made many friends, but who at the same time was retiring, quiet, keeping her troubles to herself. In her school work and later she showed an extreme conscientiousness. In her nurses' training she was always trying to place some blame upon herself. She did well as a nurse up to the onset of her illness. Four months before admission she saw two moving pictures, which dealt with selfishness and thought they referred to herself. Many ideas of persecution later developed. At this hospital she was catatonic and retarded. She wrote in a tremulous hand, with many mistakes. "I must be the murderer because they have try to give in—Everybody liberty but I have been too narrowminded. I have been against our bishop . . . . Somebody will have to take because I have told you before that I was the—traitor." Later: "I have to go out and prove I am a murderer." (Why did you say that?) "Because I couldn't get around it." A week or so later she called the nurse a traitor, and a month or so later at her sister's house she said her sister's husband was a traitor and that the devil had possession of herself. She said she wasn't loyal to one position because she went to others. Later: "I should never have been a nurse—I didn't have the qualifications for it."

In order to mention every case of self-accusation I abstract four additional cases where it appears in only fragmentary form.

1. A telephone operator of 19, in a sudden onset of confusion accompanied by convulsions, said: "Don't let me stay in the world any longer—I haven't been behaving myself—I've sinned—I imagine I have." Removed before she could talk coherently. Recovered after six months.

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2. A normal school teacher, bright, affectionate, stubborn, quick tempered and nervous, at 26 became confused, hallucinated and silly. At home she accused herself of the unpardonable sin: said she had wronged her mother and killed her. Here said: "I'm not going to get married because I am too bad." (Why?) "Oh, everything!" (Why?) "Oh, I am afraid I've broken my mother's heart!" Recovered in six months.

3. A woman of 62, deaf, after an operation and the breaking up of her home accused herself of thefts. Here she showed chiefly suspiciousness and recovered in three weeks.

4. A young, Jewish, married woman, deaf, said: "I have found the causes of my trouble—I have stolen. I am here because I tore the cotton off the slippers I was wearing. The trouble is because I ate ham." Later: "Before the baby came I did something I shouldn't have done—but it didn't hurt the baby—someone made me do it." (Eaten ham?) Discharged and lost track of.

Below I give a short summary of each abstract in the patient's own words:

A. I made a great mistake because I thought I was cock of the walk.

B. I woke up filled with evil because there was nothing to control my wicked thoughts.

C. I am wicked because of being self-centered and self-abuse.

D. I committed the unpardonable sin—I am changed—I must have done something contrary to the Bible.

E. I committed the unpardonable sin in the first 20 years of my life—I was proud and unkind to my grandmother when she had a headache.

F. I sinned—I don't know how—because I tried to take my life, etc.

G. I blame myself for my mental trouble—(self-abuse).

H. I sinned because I couldn't control a wicked imagination.

I. I abused myself—a terrible sin—There's other sins—so many.

J. I sinned because I didn't guard my own church.

K. I sinned because of self-abuse.

L. I am guilty—I think I wronged him—They accuse me, did I do wrong?

M. I must be the murderer—I was too narrowminded. I am a traitor—my work was too much for me.

The first comment is that the two cases at the end of this list do not show any conviction of sin; it is not self-accusing self directly; they are almost persuaded that other people (reference, and hallucinations) may know of some sin of which they are ignorant. The two cases emphasize that the conviction in all the rest is coupled with the fact that the wrongs mentioned are possible events of their past of which the patient should have better pictures than outsiders.

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Cases B and D felt a change. B realized that an attack of depression had come on again; she knew it from two previous attacks; it was like looking down and finding a rash. The word "evil" had stuck in her mind from the Lord's Prayer of the evening before. Finding herself depressed, she was "evil" as proved by the lack of control of her thoughts. D had no personal experience in depressions, but her mother had talked of the "unpardonable sin" in her melancholia; finding herself changed, the association with "sin" was easy, though no special sin was available. The appearance in these cases is that of a rationalization of a sadness, and there is nothing to suggest associations in the patient's mind with anything except the immediate situation.

Case C, on the other hand, at once carries us back at least 17 years, when she says she began the habit of self-abuse. She tells us that she has never matured—has always looked at things in a childish way. She had a love affair of a mild sort 18 years ago; the man stopped coming to see her; she was too proud to speak about it; she has remained single. For two years she has been restless, incessantly tormenting herself and those about her, scratching herself, threatening suicide. But she says she doesn't want to get well; she describes a double mind, her own and Satan, and days afterward she says that she is working with Satan and determined to have it that way. She is sorry she can't get away from herself—will always have to live with herself.

Is this the continuing satisfaction of an instinct denied its expression in reality? It fits in among the examples of mental regression given by Wells. Surely the surface view of this case shows at unceasing work an agent powerful enough to make an intelligent woman prefer insanity to obtain something denied to her sane moments.

In these cases what is the manifest content of the delusions of self-reproach? Sexual first; religious second; the two often in combination. Sexual ideas find expression in very obvious metaphors and symbols; "seeds" and "serpents" and "unpardonable sin" and "self-abuse" are all connected by direct statement (K); "My church is my body"; "I am pregnant by the Devil." Then come a number of trivial statements, with some indication that the patient is casting about without conviction that she has struck the right or the only sin.

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The personalities which have developed self-accusation have some striking traits in common. They are very intelligent (J an exception). Charles Reade has said that only the intelligent man was subject to remorse. All were industrious. All were doing good work in the world when taken ill, and they were taken ill late in life. All were conscientious. Most were attractive people and made friends. In all these respects they were far superior to those making up the group of depressions without self-accusation.

Let me call attention to the fact that four out of the 13 patients under consideration were trained nurses. In what training is there such insistence upon the awful consequences of small mistakes, such direct and blunt censure? And how well a hospital's tension, complication, responsibilities represent the strain of civilized life? Granted that many can draw pay year after year from a hospital without in any way letting the strain and responsibility touch their garments, such an admission only emphasizes the burden which falls on others.

On account of their very virtues these nurses and others have been prominently exposed to the strains of civilization in general. We see Kraepelin's correlation verified in these special cases. We must mention that greater civilization brings greater sex supressions, and we have found a sexual content the most frequent one. These 13 women, averaging 47 years of age, have had six children. Is lack of sex restraint the cause of lack of self-accusation among the simple Javanese and cheerful negro?

It has been unfortunate that the five recoveries from these 13 cases have been in patients who have left the hospital without giving a chance for retrospective accounts of their illnesses. Why did these five recover without direct help in solving the problem of their delusions?

IN CONCLUSION.

A study of 13 cases showing self-accusation derived from 80 consecutive admissions of women, has indicated that this symptom develops in conscientious, responsibility taking persons who are predisposed to insanity by heredity; that the manifest content is sexual or trivial, often expressed in symbols; that self-accusation apparently may represent not only a rationalization of a mood or instinct, but a continuing wish not yet reconciled to the total self.

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Further study of wider range on consecutive cases seems justified. Points for especial attack should be the relation of the personality to ensuing symptoms, retrospective accounts of recovered patients, a continual asking of the question "why?" during the psychosis, and a separation of first attacks from others.

Why restrict suggestions derived from Freud to the depths? Surface descriptions may yet prove more enlightening as to the real nature of the psychoses.

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THE PRINCIPLES OF DIAGNOSIS IN PSYCHIATRY.

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This paper offers nothing really new, but there are tendencies in our psychiatric practice which make one wish to recall to mind some of the principles that have proved effective in other branches of medical science, but which we do not always apply to our own branch, or do not do it as well or as consciously as we might.

Whenever a human being, young or old, fails or ceases to adjust himself to life in his customary way, with his customary efficiency, or in the way that would be expected of one of his age, origin, training and opportunities, we think something is the matter with him. This is a fundamental and universal assumption.

The physician is appealed to for help in getting the person back to his previous capability. In order to help wisely and effectively he must, so far as he can, determine what this something-the-matter is—that is, he must make a diagnosis.

The number of things that may ail persons is legion, and their consequences in the way of temporary or permanent disabilities or modifications of functions and behavior are greater still. In some conditions the physical symptoms are in the foreground, but in all both physical and social factors also are present, though they may have little bearing in making the diagnosis. For example, the teamster whose foot is crushed cannot work for awhile. This is a social factor, but it has nothing to do with the medical diagnosis. So it is in most of the general medical and surgical conditions.

But in the cases that come to the psychiatrist the psychical and social factors are far more in the foreground—so much so as to make us even forget or deny that there may be physical ones, or that they are of importance if they do exist. There is a tendency among psychoanalysts even to go so far as to decline to treat or consider the physical conditions that may be present. In the study of feeble-mindedness there are psychologists who declare that

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their tests alone are sufficient for diagnosis. Neither puts himself in the way to find out fully what is the matter with the patient, and hence to treat the patient most wisely.

In external wounds of the body, such as are seen on the battle-fields of Europe, the actually damaged tissues can be seen and felt by the surgeon, and the something-the-matter is patent to immediate observation. But even there the full extent of the functional disability can only be determined by methods similar to those in use in all other diagnosis.

What are these methods? How do we make a diagnosis?

We see a man who limps. What is the matter with him? Why does he not walk as other men do? In what way does his gait differ from the normal? What is the mechanism of his gait? By observation we find that the altered activity is caused by a shortening of one limb. We thus eliminate such other possible causes of limp as a broken arch, a pebble in the shoe, etc. What makes it shorter? How did it become so? We have to think of all the possibilities known to our experience, such as infantile paralysis, fracture of the hip or thigh, dislocation, etc. By inquiry we learn that the gait was normal previous to an accident a year ago in which the man fell heavily on his hip. We thus eliminate an infantile paralysis, with consequent arrested development of the limb, as a cause of the shortening, hence of the limp. By actual measurement we find the shortening to be in the thigh not in the leg, thus eliminating the possibility of a badly set fracture of both bones of the leg. Further inquiry as to the facts of the accident, and examination as to the location of pain, if any, as to the possibilities and limitations of motion, and as to any fluoroscopic or X-ray appearances, enable us to eliminate fracture of the acetabulum with upward dislocation of the head of the femur, or fracture of the shaft of the femur with imperfect adjustment of the fragments. Then, by comparison with our past experience we decide that an old impacted fracture of the neck of the femur, now healed, can give rise to the limp and all the other findings and symptoms in this case. That then is the diagnosis.

We can *see* the limp and *measure* the shortening of the thigh, but we cannot see, nor directly feel, the neck of the femur, neither can we measure it. Hence we must *infer* the impaction and the healing.

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Our conclusion, then, even in a comparatively simple case like this, is the result of a series of inferences. These inferences are *from* (1) observed facts (limp, *i. e.,* abnormal manner of walking, shortening of the thigh, limitation of rotary movement, etc.), (2) the past history (of previous normal gait, of fall on hip, of pain for a time, etc.) and (3) our accumulated knowledge of the different abnormal conditions that may give rise to the various symptoms. We ask ourselves first what functions are altered, and in what way and to what degree they are altered, and then what conditions, structural or functional (anatomical, physiological or psychical) may give rise to these alterations; that is, we ask a series of whats and whys—the *whats* to get at all the symptoms and conditions, whether of presence, absence or perversion of function or of structural alteration, that may have any bearing on the case, the *whys* to get at their underlying causes or conditions.

By the series of inferences we are led eventually *from* the factors enumerated *to* the final conclusion, which is, as it were, a sort of *final common answer* to all the whys. This is the *diagnosis,* the definition or denotation of what the matter is with the patient.

The conclusion that we reach—our concept of what is the matter—cannot be stated in a word, but for convenience' sake we use some name to denote it. It does not matter what the name is, just so that we always denote the same concept by it. We have given names in general medicine and in psychiatry for many reasons. Some have been symptomatic names, as *tic douloureux;* some have been descriptive, as manic-depressive psychosis; some are etiological, as alcoholic psychosis; some are traditional, as syphilis; some are attempts at expressing the nature of the disease, as schizophrenia.

It is the whole end and aim of all science to modify our concepts, to clarify them, define them, make them more accurate, tally more closely with the facts of nature. Yet we often keep the old words that denote them, as in the case of the word *atom,* the concept which it denotes having been profoundly altered within recent years. So in psychiatry we need to keep trying to clarify and delimit our diagnostic concepts. But this does not mean that we should keep the old lines with the old names, nor that in case of need we should not make new names. But we should avoid the mistake of expanding the connotation of words to include things

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that do not in their essence belong together, though they may have some one or more factors in common. For example, it is better to limit and narrow the significance of words like epilepsy or paranoia, rather than expand them vaguely and speak of the epilepsies, or the paranoias, just because there are convulsions in the one case or elaborated delusions in the other. It is better to follow the general medical usage, illustrated by typhus, which at first included dysentery and typhoid fever; later typhoid was limited still further, paratyphoid being separated from it; and now there are paratyphoid alpha and paratyphoid beta. It would seem like going backwards now to speak of the typhuses.

Even in general medicine we cannot always arrive at so definite a something-the-matter as in the case cited. For example, when we see a case of ordinary acute articular rheumatism we can make that diagnosis in the given case because we infer that it is the same something-the-matter which affects this case that affects all other cases of acute articular rheumatism. But we have to admit to ourselves that we do not yet know what fundamentally is the matter. Our series of inferences leads us to an unknown *M*, which we think may possibly be an infection by some sort of organism of a person inadequately resistant to it. We nevertheless make the diagnosis with a considerable degree of assurance, and keep on looking in the most probable directions for the something back of it which we rightly assume to be there. In very obscure cases we are often at a loss to reach any final common answer, our physiological and biochemical knowledge not being equal to our needs, and nothing that we know being accountable for all the symptoms.

In war surgery inference plays perhaps the least part in making diagnoses. In abdominal surgery it plays a greater part; in general medicine a still greater, and in psychiatry the greatest of all. For in the latter we have to deal with a far wider range of factors, including those of individual make-up and development, of environmental conditions both past and present, of personal and social behavior, of psychological capabilities and reactions, as well as those of present physical condition and functioning.

In psychiatry the inferences we draw are more remote and in longer chains than in the other specialties. They are less from concrete facts of observation and more from abstract data or from

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antecedent inferences. The farther away we get from concrete data the greater is the liability to error, and the less certain can we be of the validity of our inferences. Hence it greatly increases the difficulty of finding a final common answer to the questions, "Why does the patient do this, which seems abnormal, and why does he not do that, which is what we should expect of him if he were well?"

But this should not discourage us, excuse us, or deter us from seeking the answers, and by the same method as in general medicine.

Let us take a case in point. A man of 56, a hard worker, driving himself, a heavy smoker, heavy drinker till three years before admission, of nervous, tense make-up, and rather irritable, had syphilis at 33. This was thoroughly treated with mercury and iodides for two and a half years, during two of which he had gastric disturbance and a mild depression, which did not, however, keep him from work. Three years before admission he had a corneal ulceration, thought to be tubercular, though the tuberculin reaction was negative. A Wassermann reaction of the blood at that time was also negative. He was taken into partnership and conducted a steadily growing business successfully. He had a continuous and lively sense of obligation to his partner, an old man, who had befriended him. For about ten months before admission he thought, with some ground, that his partner was not carrying out certain agreements, and a few weeks before admission became suspicious of the partner's son and was very excitable and a little grandiose. Then suddenly one day he became panicky, thought a man was going to kill him, the next day that detectives were after him and that he had been poisoned, and insisted on having some vomitus analyzed. He was very unreasonable, but on being taken to the hospital accepted the situation fairly readily. For two or three weeks he was rather depressed, thought his wife, his daughter and his partner's son were conspiring against him, and was unreasonably irritable, but he was easily diverted, and then became euphoric, rather voluble and flighty, with partial insight. Physically he showed a left knee jerk possibly but not certainly a trifle greater than the right, slight incoordination of movements of upper lip and possibly of the left arm, but the pupils and all other neurological and anatomical mechanisms were nega-

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tive. Both blood and spinal fluid were negative to the Wassermann test. After six weeks in the hospital he left, still mildly euphoric, rather quickly changeable in mood, somewhat fault-finding and critical, but according to his wife "perfectly natural." Two and a half months later he called, of his own accord, to show how well and sane he was, in order that his guardianship might be discharged. At that time he was voluble, easy-going, happy, self-confident, a trifle boastful, with good memory, and apparently good judgment about his business, but still without insight as to his former delusions and the need of being taken to the hospital, but he bore no grudge. Pupils a trifle irregular in outline, but normal in reactions. Other findings were as before. He is said to have continued at his business, apparently successfully, for the past four years.

Here is a man who seems to have changed in his modes of behavior and reaction. Are the external circumstances such as to call for such behavior? If not, there must be some internal conditions. What are they? What is the matter with him? Why does he not behave as he used to? In what ways does his behavior differ from what we should expect of him in the circumstances?

By observation we see that he is easily angered and easily appeased; that he has not his usual self-control; that he is somewhat over-active; that he makes superficial snap-judgments; that he holds on to some of these judgments rather persistently, in the face of their improbability—he retains them as delusions; that his memory is good, etc.

We may infer perhaps that he is overactive and emotionally unstable because of his diminished self-control. But what causes the latter? What causes his judgment defect? What is its type? What causes the persistence of his superficial judgments?

Some of these questions we can answer by further observations and examinations, others only by suppositions and theories or by inferences from our previous experience.

By continually pushing our inquiries along psycho- and physio-pathological lines into all the symptoms and conditions that we find or infer, we come eventually to the possibility that one or more of several different things may be the matter with the patient, may underlie all his symptoms, be the cause of his changed behavior. These are (1) the effects of a more or less diffuse infection of the

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cerebral cortex and adjacent parts by the treponema pallidum in a person not sufficiently resistant to it (to which we give the name, general paralysis) and (2) the effects of some quite different but unknown condition—to my mind fatigue or something very like it—which we call manic-depressive psychosis. But these are wholly different conditions. We can eliminate other possibilities, namely, alcoholism, by the fact that he has not drunk for three years; a drug psychosis, because he has not taken any drugs; and probably cerebral arteriosclerosis, by the absence of sclerotic changes in palpable arteries, of cardio-renal disturbances, of memory defect, of tendency to perseveration, and of increased blood-pressure.

Either of the first two underlying conditions may account for nearly all the symptoms presented; neither seems to account for them all. There is, of course, the possibility that some other unknown condition may be present with one or the other, or that there may be a third wholly different and unknown condition back of it. Until the patient dies we cannot confirm our conjectures by actual investigation of his tissues. We must assume that in spite of the similarity of the symptoms in the two possible conditions, a different something lies back of his abnormalities if he has general paralysis from that which gave rise to them if he has had a manic-depressive attack. That is the ground and the necessity of our trying to make a differential diagnosis, instead of accepting the symptoms at their face value.

Thus we have to assume two fundamentally different possibilities where at least superficially the symptoms look much alike.

On the other hand we make one diagnosis, that of manic-depressive psychosis, in the cases of patients who show such widely different symptoms as those of the depressed phase, of the manic phase and of the stuporous phase. We do it only on the assumption that it is the same underlying condition which is responsible for the so different manifestations. The series of questions that we should ask ourselves leads back in each of these phases to a final common answer, which is still an unknown *X*. But it is an *X* and not a *Y* or a *Z*. On no other ground are we justified in making the same diagnosis.

Similarly, when we make a diagnosis of dementia præcox, whether of the hebephrenic, the katatonic, or the paranoid forms,

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our only justification for making it is the assumption that the same fundamental alteration or condition lies back of each case, whatever the surface manifestations may be, that lies back of all the other cases that we call dementia præcox. The final common answer to our series of questions, the final inference in our series of inferences is a yet unknown quantity, a *Y*, if you please. But it is not an *X*, or we should make the diagnosis of manic-depressive psychosis.

Though we do not know what either the *X* or the *Y* are, we must assume them to be different, even though in many cases each may give rise to symptoms which on the surface may look alike (as do the stupor of manic-depressive psychosis and the katatonic phase of dementia præcox), just as we had to try to make the differentiation in the case cited between general paralysis and manic phase of manic-depressive psychosis.

In the same way we should make all our other diagnoses, whether we reach a relatively well-known fault, as in general paralysis, or an unknown condition as in dementia præcox. In each case, however, our only scientific justification for making a given diagnosis is our belief that the same fundamental alteration or condition, whatever it may be, known or unknown, lies back of it that lies back of all other cases in which we make the same diagnosis.

That the differentiation is difficult, or even in the present state of our psychiatric knowledge oftentimes impossible, and that it often leads to unknown quantities, is no reason why we should cease to make the attempts or deny the application of the principles of all other diagnosis to this special problem. It should, on the contrary, only stimulate us to set the problem more clearly before us and work the harder to get at the real essence of the underlying fault.

In actual practice we use short cuts. Instead of going through the full process of observation and reasoning that has been outlined we look for a pathognomonic sign or group of signs. Shortening of the leg and eversion of the foot following a fall and injury to the hip so often mean impacted fracture of the neck of the femur that, finding that triad, we look no further, but make the diagnosis at once. So in psychiatry, the grouping of resistiveness, mutism, delusions and hallucinations is often translated "dementia præ-

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cox"; psychomotor retardation, thinking difficulty and despondency are usually diagnosticated as manic-depressive depression; overactivity, elation, flight of ideas too often spell manic phase; rather elaborate delusions in a person not too obviously confused or demented is diagnosed paranoia, etc. That is, we look for pathognomonic symptoms or symptom groups.

Making diagnoses in this way saves time, energy and thought, but it leads to errors, and the habit of making them in that way unfits one for solving the problems which arise in the doubtful or puzzling cases. It also stops the search for further causes or conditions, setting up a false aim for study and investigation.

Another fault in our practice is, when we find one possible cause for any given symptom or symptom group, to be satisfied with that, instead of looking further for other possible causes or conditions. For example, if there are positive findings in blood and spinal fluid in a patient with mental symptoms, we are tempted to make a diagnosis of general paralysis, even though there may be no other physical signs, and though the symptoms may be those of a manic-depressive depression with what would be regarded as quite adequate causes for such an attack in a non-syphilitic. I have such a case in mind, unfortunately not elucidated by autopsy.

Similarly, if we find psychogenetic origins for many of the symptoms in a case of dementia præcox, we should nevertheless look for other possible causes, somatic, social and developmental as well.

We need to distinguish between the cause or causes of the *disease*—that is, why the patient has any disease at all—and the causes of individual *manifestations* of the disease; that is, why, having the disease (as dementia præcox) he has this or that symptom of it. Psychoanalytic procedures often give information as to the latter, but alone are inadequate to answer the question, "Why is the patient ill?" We should expect, and we usually find, if we look for them, multiple causes for the onset of the illness itself. It is not enough to know that a general paralytic had syphilis; for, since probably only from 4 to 5 per cent of known syphilitics become general paralytics, some other factor or factors must contribute to the onset of the attack to lessen the resistance of the patient. If we would really understand the etiology of general paralysis we must consider all the other

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possible contributory factors. What applies to this disease applies with equal force to all the psychoses.

We need to remember, too, that the underlying condition does not give rise to the symptoms of the disease directly, but usually only through a chain of mechanisms. It is for this reason that we have to make our series of inferences, many of the terms of which are themselves inferences or judgments instead of facts.

For the purpose of reaching a diagnosis we have then to weigh the value of symptoms, not for their face value only, as modifying the patient's social relations for example, but for what they may indicate of the underlying alterations of structure or of function.

It is not *that* the patient has this or that symptom, as mutism or resistiveness, but *why* he has it that is important. It will be for different reasons in different cases.

We may find he is mute because of delusions, because of perplexity, or because of pure negativism, and we still must inquire why he has the delusions, the perplexity, the negativism; we must seek not only their psychogenetic origins but the physical origins as well.

Symptoms after all are either direct or indirect manifestations of altered functions, and our search should be for these altered functions, and then as to why they are altered and what alters them. It is often as important to know what a patient cannot or does not do as what he does and can do. It is only by such search that we can get the most complete and accurate concept of what lies back of all the symptoms, whether it be the presence of something that should not be there or the absence of something that should, or both.

Above all, we need to remember that the tagging of a diagnostic name to the illness of a patient is a comparatively insignificant part of our work with and for him. We should be ready to say, "I don't know," and to class the case as undiagnosed rather than satisfy ourselves by making a guess or assuming a knowledge that we do not possess. Then we have groups on which to put special efforts for study and analysis.

The difficulties are in many cases very great, and our success in solving them is so meager as often to discourage us in seeking the mechanisms not only of the deeper alterations but of individual symptoms. In treating patients we almost perforce have to con-

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tent ourselves with taking the symptoms at their face value and giving counsel accordingly. But this should not satisfy us. The principles and methods that have brought advance in other fields of medicine will do so in this—in time. Because they do not seem to help us in those cases in which we need so much help is no reason for discarding either the principles or the methods, but rather it should stimulate us to more persistent attack.

Psychiatry as a science is still very young. Our concepts of diseases are crude, still in the making. They should not be regarded as complete or fixed. But the principles and methods by which we seek to improve them should be those of all other science. That way alone lies the line of real advance.

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THE PROBLEM OF THE INDIVIDUAL PATIENT IN LARGE HOSPITALS.

By WILLIAM A. WHITE.

I think that the statement that therapy is successful in proportion to the ability to individualize the problems will go unchallenged. It has been true in all departments of medicine and probably all of us have been taught in our student days, and the students of the present generation are being taught over again, to treat the patient and not the disease. Each generation of students, however, receive this instruction at a little higher level, so that while its general principle is the same, still they find themselves closer to the individual problem.

In the large hospitals for the mentally ill the problem of individualizing the patient has always been a difficult one. It is unnecessary to trace its history further than to call attention to the fact that for the most part in the past therapeutic endeavor has been addressed to large groups of patients rather than to individuals. It is only when these various group methods of therapy have worked themselves out to the logical limits of their applicability that more intensive study of individual cases is possible, and even under the most favorable circumstances this is still largely out of the question in the state hospitals, and it has been one of the reasons why the psychopathic hospitals have been favored, because of the few number of patients and the large number of nurses and physicians which make it possible to give this sort of attention to the individual case during a period when something may be expected from treatment.

It seems to me to be a necessary corollary to these facts that individual treatment will require a psychotherapeutic approach. The trouble with the patients in our institutions is a mental trouble, and I can see no way of dealing with these cases individually which does not take into consideration the psyche. Of course you will understand that this does not mean the overlooking of necessary physical remedial agents; it merely means that no adequate under-

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standing of the individual problem can be had in the field of mental medicine which does not include an approach to the problem at the psychological level.

At Saint Elizabeth's Hospital we have at the present time two psychotherapists who devote themselves continuously to this branch of work, and in addition study the cases in connection with other members of the staff. This scheme works very well for the recently admitted patients, but there are a considerable number of patients throughout the hospital who would undoubtedly be helped by psychoptherapy but yet are, for various practical reasons, not available for this form of treatment under ordinary conditions. They are the shut-in types that preferably stay by themselves and do not associate with others, attract but very little attention and make oftentimes very little trouble, but perhaps are fairly industrious and well behaved patients. These patients, and in fact a large proportion of the hospital population, have little or no idea of what psychotherapy has to offer, and therefore make no effort to avail themselves of this form of treatment. They are very easily overlooked, especially by the physicians whose time is already crowded with acute problems.

To deal with these various aspects of the case I thought that an intramural publication might perhaps be of value, and so in the month of March of this year we brought out the first number of *The Sun Dial,* the first two copies of which all of you have received. The object of this publication is somewhat different from the object of similar publications which have been brought out from time to time in other institutions. It has primarily a therapeutic object, and while it is intended to serve all of the purposes that these other publications serve it is the intention also to do something in addition. In the first place we wanted to let the patients know something about what was going on in the different departments of the hospital. We wanted to let them know how they might avail themselves of the different agencies which have been created to help them, and, in particular, we wanted to let them know that they might have an individual discussion of their own specific problems if they so desired. To this end we have printed notices that the psychotherapists would meet any patient at such and such a time and such and such a place to discuss individual problems, and we have thus tried to get patients who felt that they

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needed help to come forward, to take the initiative in asking for it. This, probably, will bring out a few patients who can be helped. In addition to this, we have in our department headed "Talks to Patients" endeavored to give simple discussions of the various mechanisms which make for bad psychological adaptations and to put it all in simple language so that the patients can understand, trusting that many of them may make the application to themselves and see how they were the subjects of such distorted ways of adjustment. In this way it is to be our endeavor to build up a literature which will appeal to the patient class. Such a literature does not now exist, and we will have to feel our way and learn from experience, but it is my belief that a great many things can be said in this way that will be of value to the patients, perhaps not to very many of them but to a few, and that a publication of this sort, if it helps only a few, in the course of a year, to find a method by which they can get back into the world, will have served its purpose. I shall be more than glad for any comments or any criticisms, either at this time or in the future.

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DOES THE PARETIC GOLD-SOL CURVE IN PSYCHIATRIC CASES ALWAYS INDICATE SYPHILIS OF THE NERVOUS SYSTEM?

By PAUL G. WESTON, Warren, Pa.

In the course of fifteen hundred routine examinations of spinal fluid (Wassermann reaction, globulin tests, cell count and gold-sol reaction) it was found that the fluid from three patients, who had no history of syphilis and no positive Wassermann reactions and two negative luetin tests, caused a precipitate of colloidal gold in the paretic zone.

The histories of these three cases are abstracted as follows:

Case No. 9037.—Admitted August 7, 1915. Abstract by Dr. Finlayson.

Patient is a female, Protestant, housewife, age 52 years. The family anamnesis reveals a good heredity. The patient's early life was spent in Canada and her home surroundings were good. She received a common school education supplemented by musical instruction and fair progress was reported. There have been no physical illnesses which seem to have a bearing on the psychosis, except an occasional fainting spell. These she has had for years. In March, 1915, while going upstairs she fell and was rendered unconscious for about 20 minutes. She was sent to St. Vincent's Hospital and remained there for three weeks suffering from a general breakdown. Menstrual history is negative, the menapause having been passed at 50 years of age. The patient has been married twice, has borne two children and has had three miscarriages. She smoked cigarettes for many years and used morphine for two years following a surgical operation for laceration of the uterine cervix. She has used alcohol moderately but never to excess. The first mental symptoms were noted last March. After she returned home from St. Vincent's Hospital she developed the idea that her husband had been going about with a disreputable woman. Her ideas of infidelity increased and she thought her husband wanted to get rid of her. Sometimes she would scold at the firemen working near the house, telling them to go inside. She entertained ideas of persecution and thought the neighbors were stealing things from her. She was jealous of every woman in the neighborhood, chased one woman out of the house and became angry at any one who came to her door, as she said they came only to torment her. She entertained some somatopsychic ideas relative to tuberculosis and pregnancy and stated that she saw her mother appear on her bed every night. Her memory was poor in the recent field, and she became so ugly toward her husband that he had her sent to jail. She neglected her work and was careless about her personal appearance. On

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admission to the Warren State Hospital, August 7, 1915, she was boisterous, profane, untidy in her dress and exposed her person needlessly. Auditory hallucinations were not prominent at first, but have occupied her attention since, more frequently during the day than at night. Considerable deterioration, mild grandiose ideas, narrowing of the mental horizon, defective memory in remote field and absence of insight were demonstrable. She was not disoriented. Physical examination showed a fairly well-nourished woman, deep reflexes slightly diminished, pupils irregular and a diminished light reaction. At present she is very much demented but able to appreciate her surroundings, call the physicians, nurses and many of the patients by name and is approximately oriented. She knows how long she has been here and the different wards she has been on. No evidence of delusions or hallucinations could be elicited by questioning, but she became very noisy at times, undoubtedly in reaction to auditory hallucinations. She is extremely untidy in habits and appearance. No speech defect is noticeable with the usual test phrases. At times she seems to fabricate to fill in memory gaps.

Laboratory reports are as follows:

Date.	Bld. WR.	Fld. WR.	Glob.	Cells.	Gold-Sol.
9/3/15..... ..		—	+	0	5555400000
1/11/16.....	—	—	—	24	5555541000
5/6/16.....	—	—	—	0	5444300000
10/25/16.....	—	—	+	36	5555544211

Luetin tests on March 10 and March 17 of this year were negative.

CASE No. 8304.—Admitted July 23, 1913. Abstract by Dr. Darling.

Patient is a male, age 39, married, laborer, nativity, Pennsylvania. Maternal great-grandmother, grandmother, great-aunt and two aunts as well as a paternal aunt were insane. Alcoholism and neurotic taints are frequent throughout entire family. Early training was poor and educational advantages were limited. He has always been considered of a neurotic disposition and never made a success of life. For years he was addicted to the excessive use of patent medicines and for one or two years, just previous to admission (1913), he used laudanum regularly. When 28 years old he had gonorrheal arthritis which left an ankylosed right knee. When 34 years old he contracted pulmonary tuberculosis which was soon followed by "acute rheumatism" that resulted in greatly impaired motion of both ankles, elbows, wrists and cervical vertebra. At 35 he became hypochondriacal, self-accusatory, fearful of "secret orders" and developed suicidal tendencies. At the same time he imagined he heard people trying to break into his home on several occasions. His manner suggested agitated worry. This condition lasted about one year. Then although the auto-accusatory ideas persisted and his ordinary manner suggested utter dejection, he lost the real affect previously connected with his troubles, spoke of them in a matter-of-fact tone and developed much interest in the ordinary affairs of life. His present attitude towards life is summed up in his own words: "I am suffering but it gives me comfort.

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One can suffer for a good cause. When I was resurrected I was made clean." Now he is interested in current events, well informed about hospital happenings, sociable and generally agreeable. His knowledge of elementary subjects is very limited, his judgment is childish and he has but little ability to do mental work. In general memory is good, but he fails to recall clearly events during the height of his acute mental upset. The only suggestion of delusions present now is a puerile interpretation of the Bible and a tendency to explain all his troubles by religious texts.

Laboratory reports are as follows:

Date.	Bld. WR.	Fld. WR.	Glob.	Cells.	Gold-Sol.
7/30/13.....	—	..	..	..	.....
9/8/14.....	—	—	+	0	4445440000
9/25/14.....	—	—	+	0	5555421000
11/15/16.....	—	—	—	0	0000000000
5/9/17.....	—	—	—	0	4444321000

Luetin tests on March 10 and March 17 of this year were negative.

CASE No. 8958.—Admitted June 12, 1915. Abstract by Dr. Finlayson.

The patient is a female, age 43 years, married, housekeeper and a Protestant. The anamnesis shows insanity and alcoholism in the atavistic line; indirectly, epilepsy, feeble-mindedness and alcoholism and in her fraternity are found alcoholism, moral delinquency and tuberculosis. The patient's birth and early life were uneventful. She made poor progress in school and reached the fifth grade at the age of 15. She worked as a domestic until the time of her marriage but never received over one dollar and a half a week. She was married at the age of 20 to C. R., a core maker. Married life was not pleasant as the husband neglected and failed to provide for her. There were four pregnancies by this union, the first two were girls who died shortly after birth, and the other two were boys, now 18 and 13 respectively. Nothing is known about their mentality. No miscarriages occurred. The patient began to have epileptic seizures of grand mal type between 15 and 20 years of age. At first they were of infrequent occurrence, but have been increasing in frequency and severity, and some are followed by periods of confusion and irritability, but automatic states have never occurred. The patient was a frequent beer drinker when living with her hubsand and occasional intoxications are recorded. Venereal disease is denied.

The patient became incapable of caring for herself because of her mental condition and went to live with her mother about 12 years ago. She became increasingly more irritable, threatening, abusive and noisy and was taken to the county home about three years ago. She had some vague persecutory ideas relative to her friends. At the home she become more incapable mentally, threatened suicide and homicide, but attempted neither, and for these reasons was admitted to this institution June 12, 1915. On admission she was quiet, indifferent, uncommunicative, partially disoriented, showed gross speech and memory defects, low order of mentality and no insight. Attention and apprehension were disturbed. She soon became violent,

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destructive and threatening. She has had an average of four grand mal attacks per month and has become markedly demented.

Physical examination shows numerous scars due to falls during seizures, abdominal operative scar, fractured nose, absence of many teeth, enlarged thyroid, blood pressure 122, systolic, palpable radials, varicosity of veins of lower extremities, heart sounds irregular and intermittent with an accentuation of the second aortic and pulmonic sounds. Pupils are partially dilated, irregular in outline, slightly unequal and have a limited light reaction; deep reflexes are exaggerated and there is some analgesia to pin pricks.

Laboratory reports are as follows:

Date.	Bld. WR.	Fld. WR.	Glob.	Cells.	Gold-Sol.
4/3/15.....	—	—	—	6	5433000000
6/12/15.....	—	—	—	0	5544430000
8/4/16.....	—	—	—	0	5444410000
10/25/16.....	—	—	+	0	0000000000
5/15/17.....	—	—	—	0	0122110000

Luetin tests on March 10 and March 17 of this year were negative.

The colloidal gold used was exactly neutral and the tests were controlled with a number of known positive and negative spinal fluids. The Wassermann reaction was performed in a manner previously described in detail[1] and 1 c. c. of fluid was used for each test.

The above three cases were chosen because there was no history of syphilis—and it is admitted that with the insane in particular, the absence of a history of infection is of little value—and no laboratory evidence of syphilis other than the gold reaction. I do not consider an increase of globulin or the presence of twenty or thirty cells, when taken alone, to be indicative of syphilis. We have repeatedly found an increase of the globulin in the fluids from patients who were not syphilitic.[2]

What constitutes clinical evidence of syphilis of the nervous system, except in frank cases, is a matter of opinion, and the reader may draw his own conclusions concerning the cases here reported from the abstracts of the histories given above.

A number of cases have been found in which all the laboratory findings of syphilis were negative except the gold reaction, but in each case a history of syphilis, or a positive Wassermann reaction on the blood or fluid or both was obtained at some time. Here, however, are three patients who never received anti-syphilitic treatment, so far as can be determined, and who have no laboratory evidence of syphilis after repeated examinations of blood and fluid over a period of more than two years. This, of course, does not rule out syphilis, for it is much easier to prove that one has been

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infected than that one has not, and these cases are presented not as non-syphilitic but as cases not shown to be syphilitic.

The fluids from two cases showed reactions in the paretic zone on three occasions and a wholly negative reaction on another occasion. The change in reaction did not coincide with any change in the patients' mental or physical conditions. The third case, No. 9037, had four reactions in the paretic zone and no negative reactions. On two occasions there was increased globulin and increased number of cells, but no positive Wassermann on either blood or fluid. These findings together with the clinical evidence suggest syphilis of the nervous system much more strongly than the findings in the other two cases.

The question naturally arises, "Is the paretic curve produced only by fluids from paretics or those potentially paretic?"

It has been shown[3] that the gold precipitating substance is not the Wassermann producing substance and can be separated from it. The substance is dialysable and can be precipitated by ammonium sulphate and is therefore a globulin. One might speculate on the cause of the appearance of this globulin; whether these cases are not syphilitic in spite of negative laboratory findings and so on. I do not think this is the time for speculation but rather the time for gathering facts. Let us await the reports of more cases, further observations on these cases, and most important, reports of microscopic examination of the brains of these patients when they come to autopsy.

The question of whether the paretic curve ever occurs in psychiatric cases, not syphilitic, is left open.

NOTE.—Since this paper was written, the fluid from Case No. 9037 was again examined with the following result:

Date.	Bld. WR.	Fld. WR.	Glob.	Cells.	Gold-Sol.
5/18/17.....	—	+	—	0	5544421000

The result of this examination will exclude this case from the "not shown to be syphilitic" group. Incidentally, this "last minute" examination emphasizes the necessity of repeated examinations over a long period of time and warns one from hastily drawing conclusions.

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PHYSIOTHERAPY.

Its Effect, Use and Abuse, with Special Reference to its Application to the Mentally Sick.

By J. CLEMENT CLARK, M. D.,
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AND
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The term physiotherapy is derived from two Greek words meaning nature and cure and is applied to the use of nature's forces, such as heat, cold, water, exercise, rest, etc., in treating diseases. The first authentic records of nature's forces being used therapeutically were written by the Hindu philosophers and are found in the Vedas or sacred books of India. The following couplets were written about 2000 B. C.:

> Ye breezes healing blow and waft his pain away.
> The Gods have sent you forth with stores of healing drugs.

And

> Healing are the watery billows, water cools the fever's glow;
> Healing against every plague, health to thee brings water's flow.

The last two lines clearly illustrate that they had some knowledge of the therapeutic value of water at that time.

Exercise with the Greeks was almost a religion. In Sparta education was mostly gymnastic, the higher mental faculties being neglected; but the Athenians, on the other hand, aimed to secure symmetrical development by cultivating both mind and body alike and were the most perfect specimens of mankind the world has ever known.

Hippocrates diligently combated the prevailing treatment of the insane with religious ceremonies, substituting instead baths, exercise and mental diversions. He logically inferred that the chief treatment was to aid natural processes, hence his maxims, "Follow nature," and "The physician is servant, not a teacher of nature." Therefore his treatment of fever was the administration of cooling drinks and baths.

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While Rome was yet a republic, exercise and bathing became popular, and bathing houses were erected in considerable numbers, but it was not until Rome became an empire, under the Cæsars, that they were established in its most distant possessions. The baths of Rome became so sumptuous and entailed such extravagance that they eventually lost their hygienic features and contributed materially to the decay and degradation of the Roman character and bodily vigor.

During the dark ages that followed, the nobler uses of nature's forces were neglected, and only within the last two or three hundred years has their value begun to reappear and within the last 60 years have they been scientifically applied.

While the physiotherapeutic forces, rest, massage, exercise and water, are used extensively in hospitals for the mentally sick in Europe, in America physicians in general are not familiar with their physiological effect or technical application, and depend entirely too much on the judgment of physical trainers and nurses; hence, we are confronted on every side with vague directions, none or poor results and pessimism.

Physiologists teach us that exercise increases the rapidity and depth of the respiratory movements, exhilarates the heart's action and circulation of the blood and lymph, promotes heat radiation and increases the desire for food. During the metabolic changes which take place when exercise is properly indulged in, fatigue substances are formed in the muscles, which in turn are picked up by the circulation and carried to the nerve centers, bringing about a state of vasomotor equilibrium, comfortable muscular relaxation and sleep. If, on the other hand, exercise is carried to the point of exhaustion, toxic agents are formed which, when thrown into the circulation, act as irritants and excitants, causing insomnia, myalgia, disturbance of the circulation, anorexia and albuminuria. It has been pretty well proven that the same or a similar toxic substance is produced in the nerve tissue by the disagreeable emotions, such as grief, fear, anger, etc., and by excessive and prolonged mental activity.

Weicherdt claims to have been able to isolate the toxin of exhaustion and to have produced death by injecting it into the circulation of a fresh animal, he also claims to have immunized animals, in a measure, against exhaustion by injecting this toxin into the circulation in gradually increasing doses.

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Theoretically, it seems as though we might explain the different phases of the manic-depressive group on this basis, inasmuch as we have symptoms, during the period of excitement, not unlike those produced by the toxin of exhaustion, and that recovery occurs when the human organism has developed sufficient antibodies to produce an immunity. We are familiar with the prevalence of cephalalgia, myalgia, insomnia, anorexia and urinary anomalies occurring during the period of excitement, and we find these same symptoms present to a lesser degree in acute exhaustion from physical or mental overactivity. One could theorize further possibly and explain the short period of depression following the phase of excitement as being due to the overproduction of antibodies. However, we are now making some laboratory experiments on the toxicity of the blood of manic-depressive patients and the results will be published later.

Returning to our subject, exercise, we find that each individual varies in regard to his or her physiologic fatigue level; to be more explicit, some reach the point of exhaustion before others have even received the requisite amount of physiologic fatigue substances. While this wide variation exists in health, one should expect and does find a wider variation in those who are mentally and physically sick, hence the absurdity of prescribing the same exercise for a large group of acute cases, irrespective of the effect it has on the individuals. To illustrate this point, a psychasthenic patient was recently placed in my care, who had been treated for four months, without benefit, in one of the best hospitals in this country. During our first interview he told me that he had been unable to eat or sleep sufficiently, losing weight and getting hypnotics each night, and that his condition had been aggravated by excessive exercise, in the form of volley ball and other games, which had been prescribed for a large group of patients, in which he was included. To prove his point, he said, "I usually felt fairly well each morning, but after taking part in the games I became tremulous and excited, could not eat and was unable to sleep at night." I prescribed for the patient rest in bed, a generous diet and general massage. In two weeks' time he had gained 12 pounds in weight and was sleeping and eating well.

Believing that there is always more or less psychasthenia associated with the acute psychoses, it has been my rule to pre-

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scribe for all newly admitted patients rest in bed for a shorter or longer period, unless the patient is a chronic mental case in good physical health, when this rule is not followed. When I find that rest alone with a generous diet does not bring about a rapid mental and physical improvement, general massage is prescribed, the effect of which is increased appetite, better elimination and more restful sleep. When the patient has reached a state of nutrition, strength and mental control on longer requiring further inactivity, he is gotten up and graduated exercises are prescribed, consisting wholly at first of automatic acts, such as walking and slow running. After the patient is further improved, more complicated movements are introduced, and finally some form of employment is carefully selected. The patients treated in state institutions come as a rule from the working classes, and should be given some form of employment as soon as their condition permits, to preclude the formation of indolent habits, which often play an indirect important rôle in preventing recovered patients from remaining well after leaving the hospital.

Nature supplies us in water, with its possible temperature variations, a therapeutic force which, when properly applied, is capable of influencing materially both the vascular and nervous systems and indirectly the entire organism. Physiological research workers teach us that practically one-third of the total amount of the blood is contained in the vessels of the skin and subcutaneous tissue, and that this large amount of blood can be decreased or increased materially in volume by the application of heat and cold. This phenomenon is made possible not entirely, as is the prevailing opinion, by the contraction and relaxation of the muscle fibers in the walls of the arterioles, but, in a great measure, by the contraction and relaxation of the smooth muscle fibers in the skin. It is now generally believed that these muscle fibers, as well as those of the superficial arterioles in health, are capable of rhythmically contracting and relaxing, hence the mechanism is often referred to as the skin heart. Some authorities, particularly Baruch, emphatically state that if it were not for the assistance given by the so-called skin heart, the left ventricle would not have sufficient power to keep the blood in a healthy state of circulation.

Irregularities in the circulation due to functional disturbances of the sympathetic nervous system, manifested by cyanosis, pallor

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and localized hyperemia, are so prevalent among the mentally sick as to demand our attention and consideration. It is common knowledge that when these circulatory inequalities are corrected, the patients become far more comfortable mentally. The point I wish to make is that we have in heat and cold, applied in the form of water on account of its flexibility, therapeutic agents capable of bringing about this correction. I have often seen cyanosed patients with an erythrocyte count of from five to six million in the morning, after a day in a continuous warm bath, show a reduction of one-half to one and one-half million per cubic millimeter. The prevailing belief is, that this variation is principally due to the lack of fluid and that by keeping the patient in a water-jacket, as it were, preventing evaporation of moisture from the skin, the fluid equilibrium of the vascular system is restored. It is my belief that this is an erroneous deduction, because I have administered to patients, who were cyanotic, large quantities of water, and yet both the cyanosis and the high erythrocyte count persisted. It seems to me that the most plausible explanation for this curious phenomenon can be made on the basis that we have a separate nerve supply for the smooth muscle fibers of the skin, and for those in the vessel walls just beneath. When the subcutaneous vessels contract and the muscle fibers of the skin remain relaxed, the corpuscles are caught in the skin capillaries and prevented from returning, while the fluid portion of the blood is able to escape through the contracted lumina of the vessels beneath, thereby producing only an apparent polyerythrocythemia.

Psychological experiments have proven that the special sense organs, as well as their receiving centers in the brain, are abnormally sensitive in manic patients, and that a sensory impulse is augmented to such an extent as to be out of all proportion to the intensity of the stimulus; hence, when such a patient is placed in a continuous bath, with both the temperature and specific gravity much the same as that of the body, and in a room away from the bright light and noise of the ward, it has a threefold therapeutic effect: First, it prevents skin evaporation; second, it re-establishes the circulatory equilibrium; and, third, it reduces external stimuli to a minimum.

With your permission I will read a brief abstract of the history of a manic-depressive patient, which I feel forcibly illustrates the therapeutic value of continuous baths:

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Russian Jewess, age 50. Admitted December 31, 1902, with a history of having had numerous manic-depressive cycles, both in Europe and America, and of having been in a state of excitement for about one year just preceding her admission. From the date of her admission until 1915 she averaged one manic-depressive cycle each year, consisting of six months of excitement, four months of depression and two of lucidity. In 1915 the psychopathic building at Springfield State Hospital was opened, in which a rather complete hydrotherapeutic equipment was installed. Two weeks before the building was occupied, this patient became excited and, as a matter of experiment she was transferred to this building and placed in a continuous bath. After remaining in the bath for eight days she became quiet, lucid and was gotten up and dressed. She remained clear for two days, then became depressed and remained so for four weeks and then recovered. She continued well until June of 1916, when she again became excited, and continuous baths were administered. On this occasion the excited phase lasted six weeks and the depressed phase two weeks. She then remained well until January 5, 1917, when she again became excited. We felt that as the two preceding cycles were so short and mild, that recovery was not entirely due to this method of treatment, so as a matter of experiment she was not placed in the bath. Her excitement grew very intense and continued throughout January and February without any signs of abatement, but owing to the impending danger of exhaustion she was again placed in the continuous bath on March 14, 1917, and at the expiration of 12 days was mentally clear and free from psychomotor excitement. This excited phase was not followed by one of depression, and patient has remained well until the present time.

While I have found the application of the thermic irritants, heat and cold, for their tonic and vitalizing action on the blood, vascular and nervous systems and metabolism most gratifying, the best results are attained only when one studies carefully the effect they have on each individual, and regulates intensity of treatment accordingly. These thermic irritants are dependent, primarily, upon the effect produced on the nerve endings and nerve centers, but we, as therapeutists, are more interested in their indirect vitalizing action on the whole organism. Their effect on blood-pressure, heat elimination and some phases of metabolism is fairly well understood, yet there are many interesting problems still unsolved. For instance, a patient was recently admitted to the Springfield State Hospital suffering from hysterical hallucinosis, weight 97 pounds, erythrocyte count, 3,900,000 and a hemoglobin index of 60. Tonic baths were prescribed with a daily decrease in temperature and increase in pressure. At the expiration of 10 weeks, her erythrocyte count was 4,500,000, hemoglobin index 95

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and weight 134 pounds; how this very simple procedure was able to bring about this marked improvement in such a short time, I am at a loss to say. I am convinced, however, that we have in water, with its possible thermic and mechanical pliancy, a stimulant of great therapeutic value, though it is still being used more or less empirically. While its curative effect on the toxic psychoses has been more pronounced than in the other groups, yet I have found it to be a most valuable adjunct in the treatment of neurasthenics and in bringing about circulatory equilibrium and general physical improvement in patients suffering from dementia præcox.

I feel that it is our duty as practicing alienists to better familiarize ourselves with physiotherapy and to devote more thought and care in directing its use.

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RESULTS IN TREATMENT OF PARESIS BY INUNCTIONS OF MERCURY AND DRAINAGE OF THE CEREBROSPINAL FLUID.

By ALAN D. FINLAYSON, M. D.,

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The progress of our knowledge of the etiology of paresis, from a state of obscurity up to the present time, marked by the researches of Metchnikoff and Roux, Schaudin, and Noguchi and Moore, is a record which is familiar to all and does not warrant a repetition here. The lumbar puncture of Quincke, the application of the Wassermann reaction to the blood and spinal fluid, the globulin tests, cell count, and the Lange colloidal gold reaction are also familiar procedures that have opened avenues of investigation which were unknown only a few years since. As a result of a known etiology and accurate means of diagnosis serologically there has been a marked increase in the interest in the treatment of paresis.

Some of the methods of treatment have not proved as successful as one might wish, but the inspiring feature of the matter is that physicians dealing with this great problem are not now willing to rest on their oars, saying there is nothing we can do, but are working energetically, and out of these efforts some good results are sure to come. Such results are being reported in one state where the commonwealth has appropriated sufficient money and has appointed a special investigator to superintend the intensive treatment of paresis.

All observers of this disease are of the opinion that if it is to be successfully combated it must be diagnosed early and treated energetically. The agents most in favor for the past few years have been salvarsan and neosalvarsan, and, since the war shut off the supply of these, arseno-benzol and diarsenol. The two great obstacles in carrying out the foregoing advice of early diagnosis and

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energetic treatment are, first, the scarcity of men who are sufficiently trained to recognize the early manifestations of the disease and sufficiently skillful to use the agent when the diagnosis is made; and, second, the financial inability of a vast number of patients to secure the treatment. These obstacles do not obtain in large centers where skilled diagnosticians reside and where dispensaries supply the medicinal agents free or at a nominal price.

That syphilis with its subsequent ravages on the nervous system is not as wholly confined to urban population as was once supposed is a fact that is well known to workers in state institutions drawing largely from rural communities. The number of paretics admitted to the Warren State Hospital, residing in rural communities, is nearly as large as the number coming from the cities or larger towns.

The Swift-Ellis form of salvarsan medication was tried at this hospital for two years following its first presentation in the literature, and the indifferent results obtained did not justify its continuation. These results corroborated the opinion expressed by Sachs and many others that whatever benefit was obtained came from the intravenous administration of the drug. Further proof of this has been given in Massachusetts where salvarsan or allied products have been used only intravenously.

When Gilpin and Early [1] presented in 1915 the favorable results of their investigation with inunctions of mercury and drainage of the spinal fluid, the procedure appealed to the writer as opening a field for further investigation which might possibly furnish a method of treating paresis which could be used by the average practitioner with a minimum of danger and at an expense that would not be prohibitive to anyone.

To carry out this idea a certain number of paretics who were available for treatment were selected, and other cases were added later as admitted. The investigation covered by this report extended over a period of 15 months, although all of the patients were not under treatment during the entire time. In all, 20 patients were treated. Fourteen of these were selected for this report; the others were not used because the patients were discharged from the hospital or died less than four months after treatment was begun, and it seemed that this period was a minimum length of time on which to make observations.

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The method pursued was similar to that of Gilpin and Early, but differed in this respect, that the patients were given daily inunctions of mercurial ointment 50 per cent, beginning with a dram and gradually advancing to three drams. The surface of the body was divided into eight areas, and the different areas used consecutively so as to avoid an unnecessary dermatitis in those susceptible. In this way any given area was used only once in eight days. When the amount of mercurial ointment used reached three drams daily considerable difficulty was experienced in making the skin absorb it. To overcome this two areas instead of one were used each day. One patient (No. 8 of the series) reacted with such a violent dermatitis that the treatment had to be abandoned for several months. Later, no such reaction occurred, and the treatment was resumed.

The spinal fluid was withdrawn at approximately 10-day intervals. From 20 c. c. to 50 c. c. were withdrawn, the amount depending on the pressure and rapidity of the flow. The first 5 c. c. were reserved for serological examination and the remainder for chemical tests for the presence of mercury. Most of the lumbar punctures were done with the patient sitting on a chair with the elbows on the knees and the back bowed out. The site of the puncture was the space between the second and third lumbar vertebræ and the area was prepared by disinfecting with seven per cent tr. iodine. The needle was boiled, cooled in alcohol, and thoroughly rinsed with distilled water. The routine observations were: On the blood, the Wassermann reaction; on the spinal fluid, a Wassermann reaction, globulin test, cell count, and colloidal gold reaction. The spinal fluid used for the cell count was the first withdrawn, and was diluted at once in a red cell pipette 1-100 with acetic acid tinted with methyl violet and thoroughly shaken. In the Wassermann tests on the blood and spinal fluid the technic observed was that reported in detail by Weston.[3] When the term positive is used, ++++ is meant. In testing the spinal fluid for mercury, only minute amounts were expected, so that the spinal fluids of all patients were grouped to the amount of 500 c. c. and this tested. The method of Vogel and Lee[4] was used to determine the presence of mercury.

The following are short abstracts of the cases treated, with accompanying tables of the serological findings during treatment:

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ABSTRACT OF CASES.

CASE 1.—C. E. (No. 7690), female, married, housewife, no children, three miscarriages; date of infection unknown; no treatment; duration of symptons, four years prior to present treatment; convulsions, two years prior to present treatment; physical examination showed knee reflexes exaggerated, pupils unequal, irregular and light reaction diminished; original Wassermann positive in both blood and fluid, globulin test positive, no cells per c. mm., and gold solution 5555431000; diagnosis, paresis, dementing type. Result: Salivation occurred in seven weeks; after six months' treatment patient showed no improvement mentally or physically, but many negative findings serologically; treatment terminated at death.

Autopsy showed no pathological conditions which might not be found in untreated cases. The findings were as follows: Miliary gummata of pituitary; hypertrophy of the calvarium; chronic pachymeningitis (externa); membranous leptomeningitis; cerebral hemorrhage; cortical atrophy; chronic ependymitis; cortical edema, gliosis, and infarction; cerebral arteriosclerosis; satellitosis; pigmentation of ganglion cells; gliosis of the cord; pigmentation of the anterior horn cells.

SEROLOGICAL RESULTS. CASE 1.

Date of Puncture.		Blood.	Fluid.	Noguchi Glob.	Cells.	Gold Sol.
Feb. 5, '16	.....	Pos.	Pos.	Pos.	4	5555541000
Feb. 16, "	.....	"	"	"	12	5555554110
Feb. 26, "	.....	"	....	....	..	.....
Mar. 9, "	.....	"	Pos.	Pos.	6	5555552100
Mar. 25, "	.....	Neg.	"	"	0	5555543100
Apr. 6, "	.....	"	"	"	0	0012000000
Apr. 15, "	.....	"	"	"	20	0023200000
Apr. 25, "	.....	"	"	"	92	2233210000
May 6, "	.....	"	Neg.	"	28	1122100000
May 17, "	.....	"	Pos.	"	..	1112100000
May 26, "	.....	"	"	"	..	0121000000
June 7, "	.....	"	"	Neg.	..	1233221000
June 21, "	.....	Pos.	"	Pos.	..	5555443100
July 1, "	.....	Neg.	"	Pos.	..	4433310000
July 12, "	.....	"	"	Neg.	..	5554431000
July 22, "	.....	"	Neg.	"	..	0001121000
Aug. 1, "	.....	"	Pos.	"	..	0001210000
Aug. 4, "	Death.					

CASE 2.—G. G. (No. 7819), female, age 29, married, housewife, no children, one miscarriage; date of infection, probably 15 years prior to present treatment; no medication; duration of symptoms, six years prior to pres-

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ent treatment; convulsions, six years prior to treatment; physical examination showed uncertain gait, positive Romberg, knee reflexes exaggerated, pupils unequal, irregular, and practically stiff, original Wassermann positive in both blood and fluid, globulin test positive, 30 cells per c. mm., and gold solution 5555210000; diagnosis, paresis, dementing type. Result: Salivation did not occur; after five months' treatment the patient showed no improvement mentally or physically, and the majority of serological findings remained positive; treatment terminated at death. No autopsy.

SEROLOGICAL RESULTS. CASE 2.

Date of Puncture.	Blood.	Fluid.	Noguchi Glob.	Cells.	Gold Sol.
Feb. 5, '16	Pos.	Pos.	Pos.	80	5555410000
Feb. 16, "	....	....	....	..	.....
Feb. 26, "	Pos.	Pos.	Pos.	120	5555554200
Mar. 9, "	....	....	....	..	.....
Mar. 25, "	Pos.	Pos.	Pos.	1	5555544210
Apr. 6, "	"	Neg.	"	0	5555442100
Apr. 15, "	Neg.	Pos.	Bloody.	6	Bloody.
Apr. 25, "	Pos.	"	Pos.	5	5555555100
May 6, "	Neg.	Neg.	Neg.	0	5555511000
May 17, "	"	....	....	..	.....
May 26, "	"	Pos.	Pos.	..	5555542100
June 7, "	Pos.	"	"	..	5555543100
June 21, "	"	"	Neg.	..	5555555320
July 1, "	"	"	Pos.	..	5555552100
July 12, "	Neg.	"	"	..	5555555310
July 14, " Death.					

CASE 3.—L. D. (No. 8596), female, age 32, single, waitress, one abortion; date of infection, 12 years prior to present treatment, no medication; gonorrheal infection, seven years prior to treatment; duration of symptoms, about two years prior to treatment, consisting of inability to work, somatopsychic ideas of a depressive nature, and some memory defect; no convulsions; physical examination showed patellar reflexes exaggerated but equal, pupils equal and regular and having a good reaction to light; original Wassermann positive in both blood and spinal fluid, globulin test positive, 30 cells per c. mm., and gold solution reaction 5555552100; this patient received five doses of neosalvarsan by the Swift-Ellis method during the six months preceding the present treatment with no improvement mentally or physically, or change serologically; diagnosis, paresis, grandiose type. Result: Salivation occurred in three weeks; after seven months' treatment patient showed no improvement mentally or physically, and the majority of serological finding were positive. Treatment terminated by discharge from hospital.

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SEROLOGICAL RESULTS. CASE 3.

Date of Puncture.	Blood.	Fluid.	Noguchi Glob.	Cells.	Gold Sol.
Feb. 5, '16	Pos.	Pos.	Pos.	120	5555531000
Feb. 16, "	"	"	"	48	5555542100
Feb. 26, "	"	"	"	2	5555554100
Mar. 9, "	"	"	"	12	5555555100
Mar. 25, "	"	"	"	0	5555555220
Apr. 6, "	"	"	"	0	5555543100
Apr. 15, "	"	"	"	0	1244210000
Apr. 25, "	"	"	"	3	5555552100
May 6, "	"	"	"	0	1224210000
May 17, "	Neg.	"	"	..	5555541000
May 26, "	"	"	"	..	5444210000
June 7, "	Pos.	"	"	..	5555531000
June 21, "	"	"	Neg.	..	5555555310
July 1, "	"	"	Pos.	..	5555555310
July 12, "	Neg.	"	"	..	5555555210
July 22, "	Pos.	"	"	..	5555553210
Aug. 1, "	"	"	Neg.	..	5544432110
Aug. 12, "	"	"	Pos.	..	5555443100
Aug. 23, "	Neg.	"	"	..	5555552100
Sept. 2, "	Pos.	"	Neg.	..	5555555321
Sept. 13, "	Neg.	"	Pos.	..	5555553211
Sept. 16, " Discharged.					

CASE 4.—M. K. (No. 8659), female, age 47, married, housewife, no children, one miscarriage; date of infection unknown, no treatment; duration of symptoms, two years prior to present treatment, consisting of grandiose ideas, memory defect, inability to perform her household duties, and violence toward her relatives; no convulsions; on admission was euphoric, emotionally unstable, showed defects of apprehension, memory and attention, and was partially disoriented; physical examination showed patellar reflexes exaggerated and unequal, a fine tremor of lips, tongue, and hands, pupils equal, irregular, and having a sluggish reaction to light, and articulation impaired; original Wassermann positive in both blood and spinal fluid, globulin test positive, no cells per c. mm., and a gold solution reaction of 5555544110; diagnosis, paresis, grandiose type. Result: Salivation occurred in 14 months; after 15 months' treatment patient shows increased dementia, almost constant confusion and disorientation, and has had a series of convulsions; no improvement in physical signs, and few negative serological findings have been obtained. Patient still under treatment.

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SEROLOGICAL RESULTS. CASE 4.

Date of Puncture.	Blood.	Fluid.	Noguchi Glob.	Cells.	Gold Sol.
Feb. 5, '16	Pos.	Pos.	Pos.	18	5555521000
Feb. 16, "	"	"	"	18	5555554310
Feb. 26, "	"	"	"	2	5555554100
Mar.. 9, "	"	"	"	12	5555555100
Mar. 25, "	"	"	"	0	5555542100
Apr. 6, "	"	"	"	70	5555533100
Apr. 15, "	Neg.	"	Bloody.	12	Bloody.
Apr. 25, "	Pos.	"	Pos.	0	555555521I
May 6, "	"	"	"	90	5555531000
May 17, "	"	"	"	..	555555521O
May 26, "	"	"	"	..	5555554310
June 7, "	"	"	"	..	5555542100
June 21, "	"	"	Neg.	..	5555552100
July 1, "	"	"	Pos.	..	5555543100
July 12, "	"	"	"	..	5555553100
July 22, "	"	"	"	..	555555521O
Aug. 1, "	"	"	Neg.	..	5555543110
Aug. 12, "	"	"	"	..	5555542100
Aug. 23, "	"	"	Pos.	..	5555552100
Sept. 2, "	"	Bloody.	Bloody.	..	Bloody.
Sept. 13, "	"	Pos.	Neg.	..	555554431I
Sept. 23, "	"	"	"	..	5555543111
Oct. 4, "	"	"	"	..	555555321O
Oct. 14, "	"	"	Pos.	..	555555521I
Oct. 25, "	"	"	Neg.	..	5555552111
Nov. 3, "	"	"	Pos.	..	5555532100
Nov. 13, "	"	"	"	..	555555321I
Nov. 24, "	"	"	"	5	555555321O
Dec. 4, "	"	"	"	..	555555532I
Dec. 13, "	"	"	"	0	5555532100
Dec. 23, "	"	"	"	0	5555431100
Jan. 3, '17	"	"	"	0	555553211O
Jan. 13, "	"	"	"	0	5555543100
Jan. 23, "	"	"	"	0	555555311I
Feb. 6, "	"	"	"	0	555554421O
Feb. 15, "	"	None taken.			
Feb. 26, "	"	Pos.	Neg.	2	555555532I
Mar. 8, "	"	None taken.			
Mar. 17, "	"	Pos.	Pos.	1	555555321O
Mar. 27, "	"	"	"	0	4433310000
May 4, "	Neg.	Neg.	"	2	5554422100

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CASE 8.—C. E. R. (No. 9197), female, age 40, married, housewife, three children, no miscarriages; date of infection unknown; no treatment; date of onset of symptoms uncertain, but probably two or three years prior to treatment, consisting of increasing irritability, memory defect, inability to conduct her home, loss of musical skill, which had been more than ordinary, convulsions, followed by periods of confusion of a day or more in duration, incoordination, speech defect, periods of boastful euphoria and emotional instability; physical examination showed lack of coordination for finer movements, a shuffling gait with feet placed widely apart, tremor of tongue, lips, and hands, pupils unequal and having a very limited light reaction, patellar reflexes absent, analgesia to pin pricks, disturbance of temperature sense; original Wassermann on the blood negative, on the fluid positive, globulin test positive, 40 cells per c. mm., and a gold solution reaction of 5555554100; diagnosis, tabo-paresis. Result: Repeated attempts were made for several months to use inunctions, but the patient reacted with such a violent dermatitis that the treatment had to be abandoned each time up to six months ago, when it could be carried on routinely. Salivation occurred in nine weeks; after six months' treatment the patient shows not only no improvement mentally, but a progressing dementia; there has been no change in the physical signs, and with the exception of one negative Noguchi globulin test, no alteration in the serological findings. The negative result in the blood originally has been maintained throughout. Patient is still under treatment.

SEROLOGICAL RESULTS. CASE 8.

Date of Puncture.	Blood.	Fluid.	Noguchi Glob.	Cells.	Gold Sol.
Nov. 3, '16	Neg.	Pos.	Pos.	..	5555543220
Nov. 13, "	"	"	"	..	5555543110
Nov. 24, "	"	"	"	0	5555554210
Dec. 4, "	"	"	Neg.	..	5555533100
Dec. 13, "	"	"	Pos.	2	5555554311
Dec. 23, "	"	"	"	0	5555533211
Jan. 3, '17	"	"	"	0	5554431100
Jan. 13, "	"	"	"	0	5555553210
Jan. 23, "	"	"	"	0	5555555321
Feb. 6, "	"	"	"	0	5555554320
Feb. 15, "	"	"	"	1	5555555321
Feb. 26, "	"	"	"	0	5555555311
Mar. 8, "	"	"	"	0	5555552110
Mar. 17, "	"	"	"	13	5555555311
Mar. 27, "	"	"	"	2	5555542110
May 4, "	"	"	"	0	5555432100

CASE 9.—M. H. (No. 9223), female, age 59, widow, pharmacist, one child, one stillbirth; date of infection unknown; no treatment; onset of symptoms, about two years prior to the present treatment, consisting of inattention to her work, memory defect, lessened business ability, grandiose delusions, mild excitement, loquacity, and denudative and destructive tendencies; she

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was committed to a private sanitarium for six months in the year 1915, and was reported to have improved under "mild" anti-syphilitic treatment; physical examination later showed uncertain gait, positive Rombergism, pronounced speech defect, pupils unequal, and having a limited reaction to light, patellar reflexes diminished but equal, and optic atrophy; original Wassermann positive for both blood and fluid, globulin test positive, one cell per c. mm., and a gold solution reaction of 5555555200; diagnosis, paresis, grandiose type. Result: Salivation has not occurred; after 15 months' treatment, the patient shows some improvement mentally, but not approximating a remission; physically she is stronger, but has shown no change in the abnormal physical signs, and except for an occasional negative globulin test, no alteration in the serological findings. Patient still under treatment.

SEROLOGICAL RESULTS. CASE 9.

Date of Puncture.	Blood.	Fluid.	Noguchi Glob.	Cells.	Gold Sol.
Feb. 5, '16	Pos.	Pos.	Pos.	80	5555555000
Mar. 25, "	"	"	"	120	5555555100
Apr. 6, "	"	"	"	270	5555555310
Apr. 15, "	"	"	"	0	5555553210
Apr. 25, "	"	"	"	16	5555531000
May 6, "	"	"	"	12	5555555210
May 17, "	"	"	"	..	5555532100
May 26, "	"	"	"	..	5555555421
June 7, "	"	"	Neg.	..	5555555220
June 21, "	"	"	"	..	5555555210
July 1, "	"	"	"	..	5555554321
July 12, "	"	"	Pos.	..	5555554100
July 22, "	"	"	Neg.	..	5555555210
Aug. 1, "	"	"	Pos.	..	5555555410
Aug. 12, "	"	"	"	..	5555553210
Aug. 23, "	"	"	"	..	5555555210
Sept. 2, "	"	"	"	..	5555554210
Sept. 13, "	"	"	"	..	5555544310
Sept. 23, "	"	"	"	..	5555544210
Oct. 4, "	"	"	"	..	5555553210
Oct. 14, "	"	"	Neg.	..	5555553211
Oct. 25, "	"	"	Pos.	..	5555532110
Nov. 3, "	"	"	"	..	5555553110
Nov. 13, "	"	"	Neg.	..	5555543110
Nov. 24, "	"	"	Pos.	1	5555554211
Dec. 4, "	"	"	"	..	5555554221
Dec. 13, "	"	"	Neg.	1	5555542210
Dec. 23, "	"	"	Pos.	0	5555542110
Jan. 3, '17	"	"	"	0	5555555210
Jan. 13, "	"	"	"	0	5555444110
Jan. 23, "	"	"	"	0	5555543110
Feb. 6, "	"	"	"	3	5555543100

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Date of Puncture.	Blood.	Fluid.	Noguchi Glob.	Cells.	Gold Sol.
Feb. 15, '17	Pos.	Pos.	Neg.	1	5554210000
Feb. 26, "	"	None taken.			
Mar. 8, "	"	Pos.	Pos.	0	5555555311
Mar. 17, "	"	"	"	1	5555555211
Mar. 27, "	"	"	"	0	5555421100
May 4, "	"	"	"	0	5555533210

Case 10.—J. T. (No. 9241), female, age 45, married, housewife, one child, two stillbirths; date of infection unknown; husband is a cerebro-spinal syphilitic; patient received no treatment; onset of symptoms, about nine months prior to present treatment, consisting of physical weakness, memory defect, and emotional instability; physical examination showed right optic atrophy, Argyle Robertson pupil in left eye, unsteady, shuffling gait, incoordination for finer movements, patellar reflexes diminished, tremor of lips, tongue, and hands, speech defect; original Wassermann positive on both blood and spinal fluid, globulin test positive, 60 cells per c. mm., and a gold solution reaction of 5555541000; diagnosis, tabo-paresis. Result: Salivation did not occur; after 15 months' treatment the patient shows, practically, a remission; there has been no marked change in the physical signs and few changes in the serological findings with the exception of the gold solution reaction. Patient is still under treatment.

Serological Results. Case 10.

Date of Puncture.	Blood.	Fluid.	Noguchi Glob.	Cells.	Gold Sol.
Mar. 25, '16	Pos.	Pos.	Pos.	3	5555553100
Apr. 6, "	"	"	"	0	5555552100
Apr. 15, "	"	"	"	60	1134210000
Apr. 25, "	"	"	"	0	1223332100
May 6, "	"	"	"	10	1123321000
May 17, "	"	"	"	..	1133310000
May 26, "	"	"	"	..	0133210000
June 7, "	"	"	"	..	1234210000
June 21, "	"	"	"	..	5555553100
July 1, "	"	"	"	..	5555555310
July 12, "	"	"	Neg.	..	5555442100
July 22, "	"	"	Pos.	..	5555553100
Aug. 1, "	"	"	"	..	4443321000
Aug. 12, "	"	"	"	..	5555555420
Aug. 23, "	"	"	"	..	5555553100
Sept. 2, "	"	"	"	..	5555554311
Sept. 13, "	"	"	"	..	5555555211
Sept. 23, "	"	"	"	..	5555555310
Oct. 4, "	"	"	"	..	5555554210
Oct. 14, "	"	"	Neg.	..	5555543210
Oct. 25, "	"	"	"	..	5555521100
Nov. 3, "	"	"	Pos.	..	5555555221

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Date of Puncture.	Blood.	Fluid.	Noguchi Glob.	Cells.	Gold Sol.
Nov. 13, '16	Pos.	Pos.	Neg.	..	4432210000
Nov. 24, "	"	"	Pos.	0	5555544221
Dec. 4, "	"	"	"	..	0001000000
Dec. 13, "	"	"	"	1	3332100000
Dec. 23, "	"	"	"	0	1112441000
Jan. 3, '17	"	Neg.	Neg.	0	1122110000
Jan. 13, "	"	Pos.	Pos.	0	5555553210
Jan. 23, "	"	"	Neg.	0	5555532110
Feb. 6, "	"	"	Pos.	1	5555543110
Feb. 15, "	"	"	"	0	5555553110
Feb. 26, "	"	"	"	0	5555554211
Mar. 8, "	"	"	"	0	5555432000
Mar. 17, "	"	"	"	0	5555542110
Mar. 27, "	"	"	Neg.	1	4433321000
May 4, "	"	Neg.	"	0	5544311000

CASE II.—C. S. (No. 9440), female, age 37, married, housewife, no children, one miscarriage; date of infection unknown; no treatment; onset of symptoms, one and one-half years prior to present treatment, consisting of lessened efficiency in the management of her household, carelessness of personal appearance, memory defect, difficulty in articulation, syncopal attack, gait staggering and uncertain; physical examination showed a positive Romberg, incoordination of finer movements, Argyle Robertson pupils, absent patellar reflexes, analgesia of the lower extremities; original Wassermann reaction positive in both blood and spinal fluid, globulin test positive, 20 cells per c. mm., gold solution reaction 5510000000; diagnosis, tabo-paresis. Result: Salivation did not occur; after four months' treatment the patient showed some improvement, principally in her ward reaction, with no change in the physical signs, and, except for two negative globulin tests and a more typically paretic gold solution reaction, no alteration in the serological findings. Treatment terminated by discharge from the hospital.

SEROLOGICAL RESULTS. CASE II.

Date of Puncture.	Blood.	Fluid.	Noguchi Glob.	Cells.	Gold Sol.
Aug. 12, '16	Pos.	Pos.	Pos.	20	5510000000
Aug. 23, "	"	"	"	..	5555552100
Sept. 2, "	"	"	"	..	5555555211
Sept. 13, "	"	"	"	..	5555555210
Sept. 23, "	"	"	Neg.	..	5555555310
Oct. 4, "	"	"	"	..	5555554210
Oct. 14, "	"	"	Pos.	..	5555554221
Oct. 25, "	"	"	"	..	5555431100
Nov. 3, "	"	"	"	..	5555543110
Nov. 13, "	"	"	"	..	5555555311
Nov. 24, "	"	"	"	20	5555555321
Dec. 1, " Discharged.					

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CASE 12.—A. O. (No. 9484), female, age 52, married, housewife, five children, no miscarriages; date of infection unknown; no treatment; onset of symptoms, about three years prior to the present treatment, consisting of a feeling of physical incapacity, neglect of work, forgetfulness, poor judgment in the expenditure of money, and emotional instability; no convulsions; physical examination showed patellar reflexes exaggerated but equal, pupils equal and regular but having a limited light reaction, speech defect, tremor of lips and tongue; original Wassermann on blood and fluid positive, globulin test positive, 40 cells per c. mm., gold solution reaction 5555543110; diagnosis, paresis, dementing type. Result: Salivation occurred in two and one-half months; after seven months' treatment the patient shows very little improvement mentally, no change in the physical signs, and aside from some negative globulin tests, no change in the serological findings. Patient still under treatment.

SEROLOGICAL RESULTS. CASE 12.

Date of Puncture.	Blood.	Fluid	Noguchi Glob.	Cells.	Gold Sol.
Oct. 25, '16	Pos.	Pos.	Pos.	40	5555542111
Nov. 3, "	"	Bloody.	Bloody.	..	Bloody.
Nov. 13, "	"	Pos.	Pos.	..	5555552110
Nov 24, "	"	"	"	..	5555555221
Dec. 4, "	"	"	Neg.	..	5555544211
Dec. 13, "	"	Bloody.	Bloody.	..	Bloody.
Dec. 23, "	"	Pos.	Pos.	0	5555555322
Jan. 3, '17	"	"	Neg.	0	5555533210
Jan. 13, "	"	"	Pos.	2	5555543110
Jan. 23, "	"	"	"	2	5555552110
Feb. 6, "	"	"	"	0	5555555320
Feb. 15, "	"	"	Neg.	2	5555553210
Feb. 26, "	"	"	"	0	5555542110
Mar. 8, "	"	None taken.			
Mar. 17, "	"	Pos.	Neg.	0	5555443110
Mar. 27, "	"	"	Pos.	5	5555553110
May 4, "	"	"	Neg.	0	5555443110

CASE 13.—C. F. J. (No. 9509), female, age 33, married, housewife, no children, one miscarriage; date of infection unknown; no treatment; onset of symptoms, about two years prior to the present treatment, consisting of vague, depressive ideas, lessening of ability in performing her work, emotional instability, progressive irritability, periods of excitement, vague ideas of persecution and infidelity, loss of finer sensibilities, partial disorientation, and a tendency to lose her way in familiar places; physical examination showed edema of the optic nerves, patellar reflexes exaggerated but equal, clonus of the left ankle, some analgesia to pin pricks, general slowing of sensation, pupils widely dilated, equal, slightly irregular, but having a

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prompt and wide reaction to light; original Wassermann positive in both blood and fluid, globulin test positive, 30 cells per c. mm., gold solution reaction 5555554211; diagnosis, paresis, depressed type. Result: Salivation occurred in 11 weeks; after seven months' treatment the patient shows a remission of mental symptoms, with a fairly competent memory and good insight; aside from possibly slightly less active pupils and disappearance of the ankle clonus, there has been practically no change in the physical signs; and except for an occasional negative Noguchi globulin test, no change in the serological findings. Patient still under treatment.

SEROLOGICAL RESULTS. CASE 13.

Date of Puncture.	Blood.	Fluid.	Noguchi Glob.	Cells.	Gold Sol.
Nov. 3, '16	Pos.	Bloody.	Bloody.	..	Bloody.
Nov. 13, "	"	"	"	..	"
Nov. 24, "	"	Pos.	Pos.	0	5555544210
Dec. 4, "	"	"	"	..	5555553221
Dec. 13, "	"	"	Neg.	1	5555553111
Dec. 23, "	"	"	Pos.	0	5555444200
Jan. 3, '17	"	"	"	0	5555555220
Jan. 13, "	"	"	"	3	5555553221
Jan. 23, "	"	"	"	0	5555552210
Feb. 6, "	"	"	Neg.	12	5555543221
Feb. 15, "	"	"	Pos.	0	5555421100
Feb. 26, "	"	"	"	1	5555442100
Mar. 8, "	"	"	"	0	5555442100
Mar. 17, "	"	"	"	0	5555554211
Mar. 27, "	"	"	"	0	5555543210
May 4, "	"	"	Neg.	1	5555432210

CASE 14.—N. B. (No. 9515), female, age 49, married, housewife, no children, no miscarriages; date of infection unknown; no treatment; onset of the prodromal symptoms is said to have been about six years prior to this treatment, consisting of irritability and lessened efficiency; the marked mental symptoms began about two years prior to this treatment and consisted of a marked memory defect, a tendency to lose her way in familiar places, defects in articulation and handwriting, and finally an attempt at suicide; physical examination showed a weak, uncertain gait, tremor of tongue and lips, patellar reflexes diminished, pupils unequal, irregular, and having a very limited light reaction; original Wassermann positive on both blood and spinal fluid, globulin test positive, 70 cells per c. mm., and a gold solution reaction of 5555555211. Result: Salivation did not occur; after four months' treatment the patient showed a far-advanced dementia, no change in the physical signs, and aside from one negative Noguchi globulin test, no alteration in the serological findings. Treatment terminated at death. No autopsy.

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SEROLOGICAL RESULTS. CASE 14.

Date of Puncture.		Blood.	Fluid.	Noguchi Glob.	Cells.	Gold Sol.
Oct. 25, '16	.....	Pos.	Pos.	Pos.	70	5555555211
Nov. 3, "	.....	"	"	"	..	5555552210
Nov. 13, "	.....	"	"	"	..	5555542210
Nov. 24, "	.....	"	"	"	0	5555553210
Dec. 4, "	.....	"	"	Neg.	..	5555554311
Dec. 13, "	.....	"	"	Pos.	2	5555555210
Dec. 23, "	.....	"	"	"	0	5555553211
Jan. 3, '17	.....	"	"	"	1	5555533210
Jan. 13, "	.....	"	"	"	0	5555554210
Jan. 23, "	.....	"	"	"	0	5555442100
Feb. 6, "	.....	"	"	Neg.	0	5555542210
Feb. 15, "	.....	"	"	Pos.	2	5555542210
Feb. 18, "	Death.					

ANALYSIS OF SEROLOGICAL RESULTS.

Case No.	Blood.		Fluid.		Globulin.		Cells.			Gold Sol.		
	Pos.	Neg.	Pos.	Neg.	Pos.	Neg.	Max.	Min.	Aver.	Par.	Syph.	Neg.
1	5	12	14	2	11	5	92	0	8	7	3	8
2	8	5	10	2	9	2	120	0	30	11	0	0
3	16	5	21	0	18	3	120	0	21	19	1	1
4	39	2	37	1	29	8	90	0	14	37	0	0
5	29	11	8	31	13	24	80	0	21	23	0	14
6	24	0	22	0	20	2	120	0	36	22	0	0
7	24	16	37	3	29	11	30	0	6	39	1	0
8	0	17	17	0	16	1	13	0	1	17	0	0
9	38	0	37	0	30	7	270	0	28	37	0	0
10	37	0	35	2	29	8	60	0	4	27	3	7
11	11	0	11	0	9	2	20	20	20	11	0	0
12	17	0	14	0	8	6	40	0	5	14	0	0
13	16	0	14	0	11	3	12	0	1	14	0	0
14	12	0	12	0	10	2	70	0	9	9	0	0

Recently Akatsu and Noguchi [4] have shown that the Treponema pallidum develops a resistance to mercury equal to 35 to 70 times the original fatal amount. It is possible that in this series of cases the Treponemata became immune to mercury, and this might explain the negative results of the treatment.

It is interesting to note the enormous amounts of mercury which these patients tolerated without having suffered from salivation. Of the 14 cases only eight showed salivation; the time required to reach this condition varied from a minimum of three weeks in one case to a maximum of 15 months in another. Of the five cases

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who died while under treatment, none showed any evidence that the medication was a contributing factor in the death.

It is a generally accepted theory that Wassermann reactions made while the patients are receiving active mercurial treatment are of little value because the mercury absorbed causes a positive serum to react negatively. In this series we obtained positive Wassermanns from cases before and during salivation, and, on the other hand, we obtained negative results from cases which were never salivated. One patient who was receiving daily inunctions was transferred to another ward and by accident the treatment sheet was not transferred with her. Treatment was consequently omitted for a period of two weeks. For 10 weeks prior to this time most of the reactions were negative, but following the omission of the treatment the next examination showed a positive globulin test and a return of the paretic curve with the fluid. When treatment was resumed the reactions again became negative with the exception of an occasional positive Wassermann in the blood.

Several examinations on the grouped spinal fluids were made in order to determine the presence of mercury, but it was found only in the last one, at about the end of the period of observation. Only a trace of mercury was found.

In Gilpin and Earley's report, previously referred to, two cases, one of paresis and one of tabo-paresis, were treated. One case never showed a positive spinal fluid, and therefore might present some doubt as to the diagnosis. This case was treated for about 11 months; of the seven observations made on the blood, the first four were positive and the last three negative. The globulin tests were positive in each instance. The patient is reported to have improved sufficiently to hold a position requiring mental exactness, but no change was shown in his pupillary reaction. The second case, which received additional salvarsan treatment previous to the use of the inunctions of mercury and drainage of the spinal canal, was treated for a period of about seven months. The report of the laboratory examinations show him to have had at first two strongly positive bloods, and at the latter part of the period of observation, one negative followed by a weakly positive blood. The globulin test was positive in all seven instances, as was the spinal fluid. Mentally he was reported to have been capable of performing his work, but needing further treatment.

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Since the investigation under discussion was begun, Pilsbury[8] reported the results of treatment of six cases of paresis by this same method. The treatment was not continued for more than four months in any of his cases, which is rather too short a time for satisfactory investigation.

Dana,[9] before the days of accurate diagnostic methods, advanced the theory that if a patient is to be benefited the diagnosis must be made early, before extensive destruction of the brain cells, with its accompanying dementia, has taken place. Others since him have agreed with this opinion, and the present investigation gives further evidence in proof of the proposition. The writer fully appreciates the fact that some of the cases in this report were too far advanced to permit of any optimistic outlook for them, but the negative serological results obtained in even these strengthens the belief that marked benefit may be derived by this form of treatment if the disease is diagnosed early and intensively treated.

SUMMARY.

Fourteen paretics, who had been showing symptoms from nine months to several years received daily inunctions of mercurial ointment 50 per cent. Every tenth day a lumbar puncture was made and from 20 c. c. to 40 c. c. of fluid withdrawn, the amount depending on the pressure and the rapidity of the flow. A Wassermann reaction was done, using the blood serum; a globulin test, cell count, Lange's colloidal gold test, Wassermann reaction and a chemical test to determine the presence of mercury were done, using the fluid. In seven, or 50 per cent of the cases the blood Wassermann became negative and remained so for varying periods of time; one case had a negative blood at the time of admission and it remained so throughout the period of observation. In 6, or 43 per cent of the cases, the spinal fluid became negative and remained so for varying periods of time. In no instance did the blood or spinal fluid become negative and remain so. All cases had negative globulin tests at one or more examinations, but, with the exception of one case, more positives than negatives were obtained. The cell count showed an irregular decrease in all instances. In 4, or 28 per cent of the cases, the colloidal gold became negative, that is, was neither paretic nor luetic in type, but all showed "paretic curves" at some later examination. After

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15 months' treatment a trace of mercury was found in 500 c. c. of grouped spinal fluids. No mercury was found on previous examinations.

One case showed a good remission mentally, but all the serological findings remained strongly positive. Another case did not improve quite as much, but approached a state termed a remission, and has shown some negative serological findings. The remaining 12 cases showed no greater mental or physical changes than would be found in a similar group of untreated cases. The lack of correlation between the serological findings and mental conditions leaves little ground on which to base definite conclusions as to the value of the treatment.

I wish here to express my appreciation of the assistance rendered by Dr. Paul G. Weston in performing the pathological, serological, and chemical examinations included in this study, and also to my colleagues who assisted in obtaining the specimens.

REFERENCES.

1. J. A. M. A., 1916, LXVI, p. 260.
2. Jour. Med. Research, 1914, XXX, p. 377.
3. J. A. M. A., 1914, LXII, p. 532.
4. Jour. Exper. Med., 1917, XXV, p. 349.
5. J. A. M. A., 1917, LXVIII, p. 267.
6. Proceedings N. Y. Psychiatric Soc., 1904.

DISCUSSION.

DR. C. B. BURR.—Mr. President, this investigation was evidently undertaken and carried out seriously, earnestly, and with great conscientiousness. All who have heard his paper must feel indebted to the Doctor for these investigations. We listened to what he had to say, hopefully perhaps, some of us, but his conclusions were not so very different from what was anticipated from our own experience. Nevertheless, I am exceedingly glad the paper was given. There is a great deal of self-cheating in therapeutics and the truth should be plainly and conscientiously revealed. Unfavorable results thus reported are of great value in keeping our heads near the level. Again, I want to thank the Doctor for his paper.

DR. WOODSON.—Mr. President, I am a doubting Thomas as regards the benefits to be derived from the treatment of paresis. As we have all seen, some cases have more resisting capacity than others, so to speak, and they often make a marked improvement, but I think the Doctor is to be thanked for the work he has done, and as the time fixed by the Chair, three minutes, is not sufficient to discuss positive results, I move that the writer be requested to continue his investigations and report at a subsequent meeting.

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REVELATIONS OF THE UNCONSCIOUS IN A TOXIC (ALCOHOLIC) PSYCHOSIS.

By C. C. WHOLEY, M. D., Pittsburgh, Pa.,

Member of Psychiatric Staff, St. Francis Hospital; Assistant Neurologist, Western Pennsylvania Hospital; Instructor in Psychiatry, University of Pittsburgh.

The case I am going to present is of the type which ordinarily the psychiatrist would not approach from a psychoanalytic point of view. Looking at the patient clinically, we find present, in a man of 52 years, a picture of the usual type of alcoholic hallucinosis which would probably be interpreted, in the light of his history, as destined for chronic dementia. But on the other hand approaching the case psychoanalytically, we find certain psychogenetic elements obtruding themselves so persistently as to make it seem that the psychosis presents a culminating chapter in a lifelong conflict in which inherent moral, or ethical forces, have been struggling for supremacy. And it is probable that this patient's alcohol has been but a commanding instrument which has served to make possible the repressions characterizing his career. For the revelations coming out in the psychosis present evidence of a struggle toward a reintegration of the individual's social and ethical instincts upon a higher and healthier plane. At all events, the psychosis has presented the extraordinary feature of enabling the patient to view his past conduct in a spirit of social fairness, and to realize moral values to an extent altogether foreign to his previous supposedly normal existence. If the alcohol itself has not set going certain organic factors making for dementia, it is not improbable that the psychotic episode may eventuate in the establishment of the individual upon a saner and more adequately balanced plane of activity.

The patient was placed, when brought to the hospital, in the surgical ward, owing to neck wounds, self-inflicted in an endeavor to commit suicide. His mental condition was such that I was asked to see him. He was " hearing voices," they said. I found him a man of exceptionally robust physique, and recognized in

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him a patient who had come under my observation three or four years previously, because of symptoms of acute alcoholism. It had been necessary for me to interview his wife at that time, and the patient (whom I shall call Mr. N.), because of this circumstance began to exhibit toward me the customary suspicions of the alcoholic, which evidently he had carried over to the present time. As soon as these suspicions were overcome, he talked freely of his hallucinations.

The man had, until two or three years previous to this admission to the hospital, held an enviable position in business affairs. He was now entirely estranged from his wife and relatives and it was impossible, therefore, to obtain a minutely detailed account of his early years. The man himself was by nature markedly secretive. The outstanding facts of his life, however, we have at hand: He is a self-made man, aggressive and dominating in the extreme, characteristically self-assured, brusque, and uncommunicative. While not an only child, his brothers and sisters were so much older than he that he grew up in what was practically an adult atmosphere. His home was a humble one in a small town. In childhood he was of a shut-in temperament, not caring for the usual boyhood games. There was a marked affection between himself and mother; and a noticeable indifference toward his father. At 15, his father having failed in business, he set out, apparently with the utmost boldness and confidence, to make his own living and to aid in supporting the family. (We note here the significant fact that addiction to alcohol—which was to continue until a psychosis enforced his confinement in an institution—began at this early age immediately upon his plunge into a business career, a career marked all along the way by phenomenal success and accomplishment).

As to his brief history: His belief in himself was extreme. He seems always to have known exactly what he wanted to accomplish and to be able to go directly after it. Within a year or two after striking out for himself he had become an accomplished stenographer. A revealing episode occurred when he was about 17. Although he had in a very short time made rapid advancement as a stenographer, he concluded he was meant for better things and made up his mind to attach himself to a well-known business house. He went confidently to the office demanding an interview with the president. When he had been told over and

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over again that the president was not to be seen, young N., our patient, informed the clerk that he certainly meant to see the official and that he would wait for him. Thereupon he calmly stretched himself out on the couch proceeding to take a nap while waiting. Finally N. succeeded in getting into the official's presence and was curtly told that there was no place for him. The young man's appearance, self-assurance, and swagger were very much against him. (This aggressiveness appears throughout his career probably as a manifestation of an underlying timidity springing from a persisting infantile homosexual level.) He insisted that he must be taken on, that the house knew nothing about his ability, they would make a mistake to let him go, etc., etc. In the end he was employed and his rise was fairly meteoric. He had a genius for organization. He proved himself invaluable, and to within a short time of the onset of his psychosis was a chief officer in the concern. In spite of his dominating characteristics, being impatient of indecision in others and tolerating no dictation from any one, he was generally well-liked by his associates. At 35 he married an attractive, talented, and highly educated woman. He was extremely proud of her and they seemed for a time to be very happy. It is to be noted that the woman he married was of a physical type entirely in contrast with that of his mother.

At the hospital, when I was called in, the patient had passed the intensely acute stages of his alcoholic hallucinosis, and his hallucinations were already beginning to group themselves pretty narrowly about two or three themes, or ideas, around which his psychosis was to center. It was the close relationship of these ideas with incidents in the patient's history, together with his peculiar mental traits, which suggested that we had here a psychoneurosis rather than the common type of alcoholic hallucinosis.

Broadly speaking, the two outstanding ideas about which his hallucinations were now centering had to do with fears of poverty and with fears of social ostracism. It was these fears preeminently, and ideas associated with them, of which he talked in my earlier visits, and by which his conduct was being determined.

He acknowledged having attempted suicide both immediately before his entrance to the hospital, and some weeks earlier, as well, in a hotel in another city. He said he "had been driven to it by the voices." (It may be well to digress here to note that

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his recital regarding what the voices had said during his acute outbreak was what we always get from the alcoholic under such conditions. So undoubtedly the psychologic mechanism governing the suicidal attempts had presented themselves in the fashion invariably typical of an intense alcoholic hallucinosis. The regularity with which we find the alcoholic attempting suicide by throat laceration, lends confirmation to the theory that a "birth fantasy" determines the *manner* of suicide. Such an interpretation of the psychology of the alcoholic is in keeping with the theory of his homosexual fixation. The voices were "planning assassination"; he was "to be castrated"; "cruelly mutilated." And as he passed out of the state of abject terror impelling to suicide the voices "talked at him and about him"; they were "deriding and humorous"; he "is a pervert"; will not take a bath because the "water is dirty but not so dirty," the voices say, "as he is"; the setting in his "ring is emblematic of a pervert"; and he wore the setting turned inward in his palm; he has "polluted" every one he has "come in contact with"; there is "urine" in his coffee and "dung" in his food; when he turns in bed the news is "flashed all over the hospital"; he will lie for hours without changing his position because he thinks that these things signify to outsiders that he is a "masturbator"; the voices accused him of pederastic practices with "monsters, part beast and part human"; "poisonous gases" are injected into his room; "nurses are immoral"; "something is to be done to him." It is to be noted that it is not the affect-depression of the melancholic which drives these patients to suicide but an overwhelming urge to escape from an imminent death attended by the most hideous torture and mutilation. At the typical alcoholic, the voices jeer and scoff and mock, discussing at length and in minute detail the refined and atrocious cruelties to be inflicted upon him, and accusing him, with diabolical insistence, of the most disgusting sexual practices. The alcoholic's "torture" practically always includes mutilation of the genital organs.) Such typical alcoholic hallucinatory experiences had been continuous during the acute phase of the psychosis.

The "voices" (the man's unconscious, speaking) threw doubt about the legitimacy of the patient's birth. His supposed father was not his "real father." Yet there was no paranoidal development of a princely father.

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As I have indicated, the psychosis did not proceed along the customary paranoid path. There did not develop any feeling of resentment toward the persecutory voices; nor identification of these with any particular individual; he seemed to feel that he was getting just what he deserved; and that whatever machinations were directed against him were entirely justifiable. This sense of a just retribution, of a deserved reward of his transgressions was observed growing up slowly but unmistakably as the psychosis progressed from week to week.

During the three years preceding the onset of the psychosis Mr. N. had lived largely in hotels and clubs, leading a reckless, dissipated and extravagant existence; and as the purely alcoholic phase of the psychosis receded, his fears having to do with social ostracism began to weave themselves insistently about such places: He had been "in some trouble in the hotel" where he had attempted suicide; the voices told him that he would not "be allowed to go into any hotel in the future"; he had been "put out of the club"; he was "outlawed"; the voices told him he would "be drummed out of the city" if he "left the hospital"; "no hotel would take him in"; "all the hotels" had him on their "black list." Such expressions were reiterated over and over. He was "penniless"; he "must not smoke"; he ought to "save the money"; it would "pay for a night's lodging" when he should be "thrown out of the hospital," a calamity which during the first months, the voices kept immediately before him; his firm would not "take care of him"; he was constantly calling up the office to see if the hospital bill had "been settled"; he wanted a razor to shave himself that he might "save the barber's fee"; he would call up his bank to learn about his "account"; no amount of assurance would satisfy him on these points. He was only convinced that he possessed any money by having the actual currency in his hands. These interwoven fears regarding ostracism and poverty for a long time remained constantly distressing, and are only now, at the end of six months, beginning to wane.

After three months' residence in a general hospital the patient's fears became so impelling that he had to be removed to a psychiatric institution. The voices told him that he was a "coward" if he didn't get out into the world; that he ought "to do some-

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thing"; that he was "living on charity." The patient began to declare violently that he "must have a show-down"; that he must "try it out"; he must know "what would happen"; whether or not he was "outlawed"; whether he would be "drummed out" of town; whether or not any one would "tolerate him"; whether or not he was "penniless." (The patient's overwhelming money complex revealing itself so dramatically in his psychosis, together with the marked obstinacy, orderliness, and punctiliousness characterizing the individual, present evidence of the relationship of chronic alcoholism with homosexuality and anal eroticism).

Since it is the purpose of this paper to discuss the revelations of the unconscious brought out during the psychosis it is necessary to refer briefly to the fact that the three years previous to his acute alcoholic outbreak had been a period of vagabondage in which already there was being revealed evidence of a long-existing moral conflict. The patient, during this time, had estranged himself from all his business associations; and had deserted his wife, settling upon her a miserable sum barely sufficient for her maintenance; and he had made this settlement under compulsion; he gave absolutely no thought as to what should become of her. He had left his home, evincing no interest whatever in what became of it; and during the analysis it was learned that earlier even than this, he had for years, had no sexual relations with his wife though living in the same house with her. For three years he gave himself over to utter debauchery, immoral relations, alcoholism, and a reckless accumulation of debts. While all his life he had been fond of making a show with money, had scattered exorbitant fees, had been guilty of great extravagance where it could in any way enhance his own importance, yet until this period of vagabondage he had been scrupulously careful to keep within the bounds of his large income. Toward the end of these vagabond years the impulse, which was to become dominating in his psychosis, namely: to get back into safe, stable and conventional living, to return to business, began to drive him; but resort to alcohol kept preventing its execution. All his previous life the patient had been selfish, concerned for the most part with his own pleasure and comfort, yet with the return toward

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health, and absence from alcohol, we find coming clearly into consciousness a view of life which is certainly on a higher plane of normality than that which he had evinced during the years previous to his breaking up. It is not a return to his old selfishness and aggression, and insistence on his own personality, that we find evolving out of the psychosis, but a new attitude toward ethical and social obligation. He has adjusted himself to his hallucinations in a philosophical stoical fashion, believing that he is getting just what he has earned. As evidence of a final freeing of his psychic forces from former repressions, we find that he has voluntarily, with no suggestion from anyone, requested that a sum handsomely providing for his wife be assigned to her. He does not accompany this by any request that she ever return to him. He has also asked that a certain other portion be used to cancel his debts.

I offer the following summary as a psychological explanation of this patient's career: As a boy he grew up under conditions which tended to enhance a native disposition towards seclusiveness and the development of a shut-in character. There was a very strong mother attachment with fixation upon her as the ideal woman from which he never detached himself in the normal way. This accounts for much of the subsequent conflict mainly on a homosexual groundwork with which his life was filled. It helps us to explain his addiction to alcohol, beginning at puberty and reaching the climax of intensity when he deserted his wife, and his indifference to, and final desertion of his wife, who was noticeably of a different type from his mother. In one of his dreams just previous to his psychosis, he had been married to a woman who answered in a remarkable way the description he later gave me of his mother.

His component of extreme confidence in himself, indifference to the opinion of others, and extravagant money display were in the direction of over-compensation against deep-seated feelings of a decidedly opposite character. In the analysis it was revealed that in spite of his swagger, he had felt very timid when he first ventured from home. His early and continuous resort to alcohol helped still further to exalt his ego, and to prohibit a normal social adjustment. Finally the forced and artificial position which he had

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maintained for so many years collapsed as a result largely of the destructive influence of the alcohol upon his brain and nervous system. A state of delirium and physical collapse supervened during which all semblance of normal psychic functioning disappears, and a state of chaos exists. There was a disintegration of psychic guidance, and the organism was thrown back upon the caprice of primary emotions and instincts, mainly of extreme fear, chiefly terror of physical harm. When the organism had had time to recuperate from this low level, terror of pure bodily assault wanes, but with teleological precision we find the patient adapting himself on a slightly higher plane and becoming now concerned about the *means* for bodily subsistence—namely, money. Fears of poverty are in the ascendency; and closely associated with these, we find surging into consciousness at this level of reintegration, anxieties and fears regarding the opinion of his fellow men, without whose good will and co-operation it will be impossible to obtain money, which means food, or self-preservation. Some of the affect which attaches itself now in the way of anxieties regarding money and public opinion, has, to my mind, carried over from the days of his childhood and early youth, when similar misgivings were bottled up and reacted against by a development of feelings of over-boldness, and disregard for money. Finally, the unconscious lays bare before us in his psychosis the elements of a life-long struggle, and a psyche brought face to face with primary instincts of self-preservation in the over-realistic coloring of an hallucinosis. With further re-establishment of bodily health and nervous vigor, we see those later-acquired evolutionary accomplishments of the psyche having to do with custom and convention, equity and ethics, revealing themselves in the patient's thoughts and conduct. Fears of poverty and social ostracism weaken; and definite steps are taken to square himself with his creditors and properly to provide for his wife.

The course of the whole psychosis has to the present time been away from the development of a systematized paranoid delusional state, and in the direction of reintegration upon a wholesome, normal, psychological level, which must be looked upon with considerable prognostic favor.

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DISCUSSION.

DR. WHITE.—Mr. President, I do not know how a psycho-analytic paper got into this meeting, but I want to congratulate the Association upon it. The fact is most encouraging.

It is pretty difficult to discuss a complicated paper of this sort, but the general picture of the alcoholic hallucinosis is rather typical and I want to say that we would never know anything about it if we simply said that the patient had hallucinations and put down stenographically the content of those hallucinations. The doctor has worked out in his analysis the meaning of those hallucinations, to some extent, at least; how they symbolize the conflict of the individual, and he has been able to help the patient effect readjustment in such a way as to effect a social rehabilitation and this is a therapeutic endeavor of the highest kind not to be put down by absurd criticism owing, perhaps, to its more dexterously worded comments. The alcoholic hallucinosis is almost invariably an outgrowth of the homosexual life. The tendency of hallucinations invariably point to that homosexual level. I think that the effort at suicide was perhaps not an effort at death but perhaps is a birth (re-birth) phantasy. If we are going to bother about the literal meaning of words, meanings which hark back to infantile ways of thinking, we will not understand; and the reason we will not understand them is that we have passed beyond these meanings and we have to go back in our cultural history. So we can talk over and argue as to pathological symbols that indicate different levels in the cultural development of man, and we have certain types that might be correlated with these levels that are found in the various cultural strata, so that for instance, the alcoholic hallucinoses refer to a certain stage and cannot be understood unless in these terms. If we stick to the terms of our adult level we will be shunted aside from such investigations. We are going to understand something about alcoholism as soon as we get the psycho-analytic studies completed. Alcohol in this case has not been a destructive element. While it does not serve the patient any permanently useful purpose, and while we should keep far away from recommending it, it does help and it did help him out of his difficulties in some ways. Some persons know well that alcohol has advantages; they talk about drowning their sorrows; they talk about its giving them Dutch courage, and it certainly does give them a certain ability; it does assist certain types to socialize their libido. I know people who are at times incapable of any contact with other men when sober and yet with a little bit of alcohol they can effect a certain amount of social efficiency. This is a bad type of character reaction and cannot be recommended ultimately, and yet this is one of the reasons alcohol is used. And unless we find out the fundamental things that it supplies in the individual, we shall never be able to deal with these cases in a way that will be permanently helpful to them.

I am exceedingly glad that the paper by Dr. Wholey should appear here and I feel that the Association should stand by interpretative psychiatry laying aside destructive criticism and taking on constructive criticism; and that we should not rest until we have progressed further in this work.

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DR. WALTER B. SWIFT.—Last week I showed before the psychopathological meeting in Boston that delinquency might be interpreted as a central lack. I have already endeavored to show that the spasmodic action of stammering may be traced to a "Visual Asthenia" a weakness in the imagery that goes on during normal speech. It seems to me that the substance of the paper just read and this condition mentioned by Dr. White can also be interpreted along that same line, but before I present my own interpretation I would like to illustrate something that Dr. White has already mentioned about getting back to the early life activities. It is known, that when college men go from high school to play football in college, they have a certain set series of mental reactions that are well instilled. They play according to those reactions. During their training in college-football they are brought up to another high standard of mental reaction in this play. Here are *two levels* of training. Now when they go to exhaustion in some big game they revert form this newer level that they have learned in college-football, to the lower more simple psychological reactions learned in the high-school-football. Now, it seems to me that this is an illustration of what I mean by an asthenia. In this whole field there has been a misinterpretation. Instead of an exacerbation of libidistic outflowing, the output of excess things is due to a lack due to asthenia. The interpretation of all these excesses of motor output should be hyperkinesis by asthenia.

DR. WILLIAM MCDONALD.—Mr. President, I would like to take this opportunity for one word. It has been intimated that I am an iconoclast and I wish to state that I am nothing of the kind. I would further state that whatever criticism I have made during the last day or two on psychoanalysis is not destructive. The psycho-analyst says that we do not agree with him because we do not understand; that we do not know even the language of psycho-analysis. This is probably true. Dr. White says, "If you are going to destroy our theories and interpretations replace them with something else." Now, if we do not know what they are talking about, how can we do it? We simply demand that they present facts. It seems to me that in using terms such as the homosexual level and the like, that the speech is meaningless. They speak of split personalities; of *Sally A.* and *Sally B.;* of Sally the woman, the angel and the devil. How do they know that there are any such personalities. If there are levels show us how their existence is recognized. I say such talk is nonsense or else my brain has gone bad, for I cannot understand it. It is symbolic talk and idle interpretation. Such psycho-analysis seeks to build the ladder from the top; you must build it from the bottom and place its base on fact.

DR. SOUTHARD.—Mr. Chairman, many of the Freudian so-called quoted "facts" are peculiar interpretations of real facts that we all recognize. Take the term *libido* with all its unwarrantable extensions over a variety of real facts. Claparêde, I believe, has suggested that the word *interest* covers much of the so-called *libido,* but if we follow Claparêde's suggestion and replace *libido* with *interest,* what becomes of many of the libidinous

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facts? A mob of men, a homosexually libidinous mob, turns into a crowd of men with a common interest. What is the difference between a "stag party" with a common *libido* and one with a common *interest?* Apparently, precisely no difference whatever! If we remove the sexual shudder from these descriptions we are left—exactly where we were before. A frequent phrase nowadays is—"translated into psychoanalytic terms we would say," etc., but why translate? Personally, I shall not wish to translate, unless I can get more from the translation than a superfluous sexual shudder.

THE PRESIDENT.—Does Dr. Wholey desire to add anything in closing the debate?

DR. WHOLEY.—Mr. President, I appreciate Dr. White's remarks regarding this paper. In the face of the prejudice against Freudian theories, those who undertake modern psychological interpretations of the psychoses, welcome such encouragement.

As to the question of the significance of asthenia in such patients, I think the asthenia element merely serves to reduce the patient's psychic activities to the level at which these libidinous outflowings come into consciousness with more facility. This fact does not contradict the Freudian theory in any way. Just as the toxic effects of alcohol may break down the barriers against repressions, so in states of exhaustion a patient may reveal his complexes in a hysteria, or psychosis.

As to the question of the "facts" supporting psychoanalytic interpretations, it seems to me unnecessary to restate facts which are definitely established. We are dealing with psychobiology, and we find the relationship of cause and effect occurring as precisely as in the realm of chemistry where the union of certain elements combine under given conditions to produce certain results or compounds.

As to the question regarding the substitution of the word "interest" for libido, I can see no purpose in doing so unless "interest" connotes the equivalent of libido. If it is used merely to appease prejudice, I think it is misleading and to be condemned.

The suggestion that every social gathering of men is interpreted by us as an evidence of homosexuality in a degenerate sense, is a misinterpretation of our position. Such an interpretation would be out of keeping with the facts of normal psychobiology. Homosexuality is a normal instinct and plays an important rôle in the development of the individual's heterosexuality.

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EXTRA ASYLUM PSYCHIATRY.

By L. PIERCE CLARK, M. D., New York.

I think all of us are aware of the great change that has come over the character of medical work done in state hospitals for the insane, as compared with that of a quarter of a century ago. Formerly if one had suggested to the asylum medical interne that he should take careful notes of even his general medical work to assist him in outside practice, he would have been laughed to scorn. What with the lack of facilities for diagnosis and treatment of general diseases, the amount of experience the physician obtained in a state hospital for the insane, his time thus spent illy equipped him for any sort of general practice in the outside world. What a change in this respect has been brought about since that time! I venture to say that there are few general hospitals outside the large cities that train their internes for the general practice of medicine as thoroughly as the average well-appointed hospital for the insane to-day.

To follow the same idea further: Formerly an interne's chance to use his special knowledge of mental disease in private practice was absolutely nil. Indeed, I myself was told by several eminent neurologists that I had better not mention my interneship in asylum work if I expected professional advancement in outside practice. Aside from a chance to make legal commitments and become associated with private sanataria, the professional opportunity to use one's special knowledge was practically non-existent.

Two obstacles have slowly been overcome to bring about a better situation for asylum physicians. The first and greatest one has been the radical departure in the character and quality of work expected of the state hospital physician. I need not tell you, who perhaps know better than I, what this change has been. One needs but to look at the type of examination and case records, now kept in the modern hospitals for the insane as compared with those made formerly, to fully appreciate the great signifi-

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cance of the improvement. Formerly the records of the insane were perfunctorily done and concerned themselves largely with mere anecdotal sketches of the several psychoses. At present they are the equal if not the superior to any in any branch of internal medicine. Nor do the preliminary records merely note the improvement. The continued study of the psychoses in their changing reactions are detailed and precise, hardly equalled in neurologic medicine. Yet, with all these changes and improvements in the type and character of asylum training, the hospitals for the insane as a whole need to look closely to the general character of their work in future. This warning is in part due to the rapid advance which psychiatrists have brought about in the minds of the general public. The latter has grown to expect that with our keen mental training and sharp insight into the causes of insanity, that we all shall take a more active part in stalling and preventing the community forces that make for mental dilapidation in its broadest sense. The complaint psychiatrists often make, or used to make, that the mental cases are not brought to the asylum early enough for successful treatment will not of itself correct this evil in mental medicine. We must train our young men to take a more active part in extra asylum work, the pre-asylum mental clinics, the after care work and all that concerns the mental hygiene of the community. Many such activities are here and there in evidence, but we must enlarge and extend them. The work must not begin and end here; we should give our hearty support to the extension of psychiatric experience in the school clinics, to poor authorities, the courts, not only children's but the adult courts including those dealing with domestic relations, the police and the like agencies dealing with mal-adaptive and socially unstable persons. Many of us might possibly disagree as to the exact diagnosis and classification of the mentally unstable individuals, who come before these agencies for help or correction, but if we avoid pigeon-holing or labeling them, and look frankly at the practical problem they present, I think all would agree in the main upon what the striking faults are and settle upon a practical corrective plan of care and treatment such individuals should get from us. I think we can't begin too early to train the asylum psychiatrist to take part in this work. It should go hand in hand with his more precise and technical intramural training. In both

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fields of work he should, of course, work under and with trained men. A closer association by medical societies with his outside medical brethren in the community life about him makes the asylum psychiatrist keener and broader in his view of the forces that make and destroy mental health. But we must not stop here in our medical guild spirit but engage with as many of the community activities as possible. The latter, especially, will increase and broaden our cultural background as well as quicken our diagnostic acumen and therapeutic resourcefulness, even though the asylum physician may not ever care to engage in outside practice. I think in the past we have been a little too apt to look on the interne who hopes ultimately to take up extra asylum practice as one who should be discouraged in such tendencies. Inasmuch as the great majority probably pursue this course we should give encouragement instead of discouragement to them. I venture to say that at least half of the average neurologist's private practice is, in its broadest sense, psychologic if not distinctly psychiatric, and a training along the latter lines will eventually be the greatest asset for gaining and keeping a neurologic practice. Mild types of manic depressives, the beginning præcox disorders, and all the psychoneuroses ought to be largely in the hands of psychiatrically trained physicians. Such cases come to the outside neurologist months or years before they break down into frank mental disorders requiring asylum care. This fact should be a great incentive to state hospitals to steadily train their internes to look forward to entering this private field when professional preferment in the hospital service is not at hand. Perhaps to further this trend a third or a half of the interned staff could easily be allowed to live outside the state hospital where community life and its stimulus would help to further the ends of both the physician and the institution served.

It is impossible for me to more than outline the extramural advantages for well-trained psychiatrists in public service to-day. For instance, there are scores of permanent and well-paid positions and their numbers are increasing daily, for medical men psychiatrically trained and capable by general temperament to fill these important places in this country. The call for these men is increasing daily. The chance for public service, however, is but an insignificant field of extra asylum activity compared with

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the earnest demand for such psychiatrists in private practice in every large community to-day. The cultivation of that sort of tact commonly learned by the average physician in his first years of private practice should be a distinct part of the asylum physician's training if he is to succeed in the outside field later.

Finally, one may question, where are we to get able men to go in for this sort of psychiatric training? I think we must encourage all teachers in the medical schools to set before their students the attractions and the chances for professional and social advancement such psychiatric training possesses. We should all work for this end by seeing that as many capable and bright young men enter this field of medicine as in other fields of internal medicine and surgery.

In conclusion, I believe the more actual bedside teaching the subject of psychiatry receives in the schools, the more students will be encouraged to take an interest in psychiatry and thus advance the interests of our specialty everywhere.

DISCUSSION.

DR. ROSANOFF.—Mr. President, it pleased me very much to hear Dr. Clark's paper. Nearly a year ago a survey of mental disorders in one of the counties of New York was undertaken. That survey was undertaken with no idea of the multitude of psychiatric problems that existed outside of the institutions. When we got through we came to realize that cases presenting psychiatric problems existing outside were much more numerous than those which had been taken care of through institutional provision, yet this is only one piece of work. It is, therefore, especially interesting to note that a gentleman of fine psychiatric experience, who has subsequently gone into private practice of neurology and psychiatry, finds problems identical with those that we found. The independent observation of data made by two workers, not working together, makes the findings of either one much more trustworthy than they would be alone.

DR. ABBOT.—In my student days, when I was already thinking of seeking a position in a hospital for the insane, one of the teaching staff at the medical school asked me "What do you want to bury yourself out there for?" That fairly represented the prevailing attitude of the general physician at that time. This attitude is changing and the general physician is beginning to see that there are mental sides to every case. The more they see, the more there will develop a willingness to encourage rather than to discourage the students' going into the specialty of mental diseases. An evidence of this change is the opening of a psychiatric out-patient clinic at the Massachusetts General Hospital this spring.

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DR. HARRIS.—Mr. President, it seems to me that it is along the lines as stated by Dr. Clark that we have a way in which we will be able to do great good to the community. I have thought that medical colleges should take up the question of psychiatry and have it taught in the same way that general medicine is taught; that clinical material for proper study should be furnished by the hospitals where mental cases are received, and that the medical students should have bedside instruction in a hospital where every form of mental disease is treated. It seems to me that it would be well for the majority at least of students graduating in medicine, to spend considerable time in a hospital for the care and treatment of mental cases. There is a wide field for usefulness. I remember very well upon entering the hospital service in New York a number of years ago, that the salaries were very small, something like $25 per month, but now medical internes start at $1000 per annum and maintenance, and yet nearly all of the hospitals suffer from lack of physicians. I think this would be remedied only by a process of education along the lines suggested by the various speakers.

DR. RUSSELL.—Mr. President, it seems to me that this is really quite an important subject. Here in New York and in other parts of the country you can see a great demand for psychiatrists outside of institutions; and there is one point which I would like to bring forward; and that is that psychiatric work is really being taken up by people who have no medical training and yet are known as clinical psychologists, etc.; and unless the physicians who are trained in psychiatry do go into that field, with proper instruction, there are going to be complications and difficulties which I think will not react beneficially to the medical profession or to the community.

DR. WALTER B. SWIFT.—Mr. President, I should like to confirm the remarks of Dr. Russell. Since my arrival here in New York I have been approached by several "so-called psychologists" trying to take over the functions of *trained psychiatrists*. On the card of one I find psychoneuroses put down with other matter that points to their being "mental specialists." This is surely a serious matter and an imposition upon the public. It suggests that we need a broader definition of medicine in law.

DR. CLARK.—Mr. President, many of us here in New York have been made aware of the fact that a number of psychologists have been making a definite effort to preempt the field of our cases under the semblance that they are treating them at the request of physicians. We know of several psychologists who are trying to practice in this city, and the New York Psychiatrical Society is taking up the matter and is also publishing resolutions about it in the medical journals. It is an unfortunate fact that oftentimes the school authorities and the public think that when there is a definite maladjustment or disorder of conduct in children, these issues are for the psychologist to set straight and not the trained psychiatrist. If the psychiatrists would but more fully recognize their obligations and the breadth of their work in these borderland fields of medicine, it would result in fewer psychologists trying to practice medicine.

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OCCUPATIONAL AND INDUSTRIAL THERAPY. HOW CAN THIS IMPORTANT BRANCH OF TREATMENT OF OUR MENTALLY ILL BE EXTENDED AND IMPROVED?

By L. VERNON BRIGGS, M. D.,
Member of the State Board of Insanity of Massachusetts 1913, and Secretary 1914, 1915, and 1916.

In picking up the history of occupational work in our institutions for the insane, I have found nothing in medical literature that would even touch the researches of Dr. Hurd on the subject in his most complete and truly remarkable history of "The Institutional Care of the Insane in the United States and Canada." I confess to having abstracted bodily from this volume much of the historical matter used in this paper.

As early as 1847, Dr. Amariah Brigham, superintendent of the Utica Asylum, published a paper on "The Moral Treatment of Insanity," in which he took issue with Dr. Rush's then prevailing views on the treatment of the insane. The latter says, for instance, that "the first object of the physician when he enters the cell or chamber of the average person should be to catch his eye and look him out of countenance. He should hear with silence their rudeness or witty answers to his questions, and upon no account ever laugh with them or at them." After enumerating the various means of making insane persons obedient, Rush continues: "If these prove ineffectual to establish a government over deranged persons, recourse should be had to certain modes of coercion." Among the methods recommended are the straight-waistcoat, the tranquillizing chair, the deprivation of customary pleasant food and pouring cold water under the coat so that it may descend to the armpits. If these methods likewise failed to produce the desired effect, he regarded it as "proper to resort to the fear of death."

With these views of Dr. Rush's Brigham entirely disagrees. He regarded bodily labor as one of the measures necessary for the moral treatment of the insane, and he expressed the hope

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" that in the future arrangements will be made by which the inmates of insane institutions will be better able to avail themselves of this means of cure." He recommended in 1847 that every institution should have a farm connected with it, and that there should be workshops where " dressmaking, tailoring, basket-making, shoemaking, painting, printing, book-binding and other employments should be carried on by patients who could not be employed on the farm." Manual labor he considered beneficial because it engages the attention and directs the mind to new objects of thought, but feared that in some instances, especially in convalescence from acute diseases, it might do harm and produce mental excitement. He believed that manual labor was most useful with incurable patients, since by preserving the health and arresting the tendency to mental impairment, it rendered their condition more comfortable. With curable patients, on the other hand, he considered mental occupation more beneficial, especially employing the mind in pursuits which engaged the attention, suggested new objects of thought and enlarged and improved both the mental and moral powers.

Institutions, he thought, should be supplied with books, maps, scientific apparatus and collections in natural history. Schools should be established in every institution where patients could learn reading, writing, drawing, music, arithmetic, geography, history, philosophy and the natural sciences. These schools should be in charge of intelligent instructors who would give all their time to the patients, eating at the same table with them, joining in their walks and recreations, providing them with amusement, and undertaking no labor or duty except that of interesting those under their care, and contributing to their happiness by conversation and companionship. They ought not to have anything to do with coercive measures, in order that the patients should not be prejudiced against them and become ill at ease in their presence. They should encourage the timid, comfort the despondent, and contribute to the cheerfulness and contentment of all. He believed that schools are especially useful in arousing the patients and calling into exercise the faculties of the mind which had become dormant and inactive. While walking, riding, etc., soon became mechanical, and therefore furnished but limited enjoyment, attend-

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ing school, he believed, provided mental occupation which, by requiring constant attention and effort, really interested the patient. Dr. Hurd says: "It is evident that Brigham, in this respect, was far in advance of his time, and possibly of any time."

How far have we carried out these ideas, and have we really made any further progress?

In the first number of the AMERICAN JOURNAL OF INSANITY, the good Dr. Brigham describes efforts made to employ patients in the State Lunatic Asylum at Utica, N. Y., which certainly seem, in some respects, to be far in advance of anything our hospitals are doing now. He says: "Attached to the asylum at Utica is an excellent farm, where the patients in good weather perform much labor, and also in the garden, by all of which they are much gratified and improved. Some work in the joiners' shops, some make and repair mattresses, and others work at making and mending shoes. The women make clothing and bedding, and do the ironing and assist in various household duties. They also manufacture many useful fancy articles for sale." He goes on to describe a fair that had been held a month before for the sale of articles manufactured by patients at the asylum, and quotes a passage from an article in a daily newspaper showing how everyone was surprised at the beauty of the fabrics, and the skill and ingenuity displayed in their manufacture. There were dolls of every dimension, baskets, caps, stockings, gloves, aprons, collars, bags, purses, etc., in abundance. Schools for both sexes had been established, at which good results had been obtained. The winter session of the school had been closed by an exhibition at which there had been given original pieces, recitations, music and original plays, which would not have been discreditable to any literary institution.

"Those who do not labor," says Dr. Brigham, "pass their time reading, playing ball, rolling ninepins, walking or attending school. The women work much of the time; they also take drives, walk, play battledore and attend school."

In the next number of the JOURNAL he gives a description of the school: "There are three schools for men, one managed wholly by a patient, the other two by a teacher hired for the purpose, and one school for women conducted by a hired teacher. School

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sessions commence at ten in the morning and at three in the afternoon, and each session continues for one hour. They are opened and closed by the singing of a hymn. The patients read, spell, answer questions in arithmetic, geography and history, and are assisted by blackboards and a globe. The majority commit pieces to memory, and once a week there is a meeting of all the schools in the chapel, where they unite in singing, which is followed by declamations, reading and compositions. Some patients have learned to read and write in these schools. Several who have been depressed have been much improved by attending school, and a considerable number who were approaching a demented state have been improved in mind and have become interested in learning."

In a later article Dr. Bingham describes what he calls "whittling schools," in which, "in addition to carved reproductions of all ordinary objects, such as houses, temples, ships, chains, etc., as well as all four-footed, two-legged and creeping things, there are many works of pure imagination, presenting marked characteristics of the *asylum school!*"

Dr. Hurd continues in his account of Dr. Brigham's work: "The theory held by Dr. Brigham and also by Dr. Todd of Hartford was that employment, to be of benefit to the patient, should not consider the question of gainful occupation. In their opinions it should be of a character to divert the patient from his morbid fancies, to engage his attention, stimulate his interest, and lead him to resume natural and healthy methods of thought and occupation. Hence Dr. Brigham advocated the establishment of the whittling shop mentioned above, and also made plans for a printing office and other industries in connection with his institution. He spoke repeatedly of the advantage of household occupations and gardening and flower raising for women, with labor upon the farm and garden for men. It will be observed that these schools were part of the hospital routine. As long as Dr. Brigham was superintendent, and during the superintendency of Dr. Benedict, his successor, they continued in operation. Under Dr. John P. Gray they were discontinued." Except for the addition of gymnastics, dancing, etc., and for the development of the more strictly artistic handicrafts, little seems to have been devised in any state

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hospitals in this country since Dr. Brigham's day in the way of diverting and occupying patients. Indeed we might do well to revive several of his devices, especially the well-conducted school and whittling classes. Considering that our hospitals are necessarily under the direction of medical men, it is not surprising that the pedagogic side of the treatment has been neglected; but with our wider present-day knowledge of abnormal psychology it must come once more to the fore. It is true that our medical men are not trained to conduct schools, nor have we, many of us, the scientific knowledge of occupational therapeutics. Why not put these matters in the hands of trained educators, under medical direction? It may even be possible in course of time to effect cooperation with boards of education along these lines.

In the meantime, some sort of occupational work is being done in all of our state hospitals, but the various branches of instruction are best carried on where the superintendent or one of his assistants has some paticular hobby. Even the school idea is by no means neglected. Dr. Eyman, of the Massillon State Hospital (Ohio) is quoted in Dr. Hurd's book as saying that, "During the past year (1915) a school has been in session at this hospital. Through private donation a sum of money was obtained to purchase the material, and under the direction of the superintendent, the work of construction was practically done by the patients." He then describes the building, and continues: "Two teachers are provided for the school, and about a hundred patients per day are in attendance. Three sessions are held daily, two for women and one for men. The subjects are oral arithmetic, reading and spelling. The patients, in addition, are encouraged to relate stories from their experience, bearing on whatever subject is under discussion. There are also spelling contests and special recitations and songs. Free-hand drawing and the study of German have been introduced and special classes in history and geography have been formed. It has been the aim of the superintendnt of the hospital to make an appeal to the patients to recall and reproduce, as vividly as possible, their former school days, and to awaken and stimulate early associations, with the hope that the stream of thought may thus be brought back to a natural channel. An effort is made to vary the instruction and to give a sustained

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interest in the exercises. The questions and subjects are simple in character and the patients are encouraged to speak of the ideas which the lessons suggest to them. The last 20 or 30 minutes of each session are given to calisthenics in the gymnasium, beginning with a simple march to music and followed by a simple gymnastic drill, with definite commands and without apparatus. At the close of the drill the patients join in old-fashioned games like drop the handkerchief, London Bridge and fox and geese.

"With the development of non-restraint methods it became essential to supplement household duties by occupations and industries calculated to engross the attention of all classes of patients, acute as well as chronic.

"In some states a law exists whereby authority is given to medical officers of institutions to give employment to patients solely as a mode of treatment."

From time to time periodicals have been issued by patients in various institutions, beginning in the Hartford Retreat as early as 1837. In 1847 a regular newspaper, *The Asylum Journal,* was issued by the patients of the Vermont Asylum for the Insane at Brattleboro. This continued successfully for five years, but was discontinued on account of the recovery and discharge of the printers. Perhaps the most successful of such periodicals was the *Opal,* issued from the Utica Asylum in the 50's. This paper had a large circulation and was very successful for some years, but gradually interest dwindled. We are told that the editor, the printer and the binder declined in mental power from the progress of disease and soon afterwards died. We may trust, however, that their deterioration was delayed by their activities. Dr. Hurd cites as one of the causes for the decline of this journal the recovery and discharge of some of the best contributors. He says in regard to these periodicals in general: "They prospered for a time owing to the industry and initiative of some one person who felt responsible for them, and ceased to exist when by recovery or otherwise the individual passed from the institution." Does not the very fact that these periodicals have been discontinued after a short period of enthusiasm indicate that they have accomplished their therapeutic purpose?

Therapeutic occupation for the mentally ill, and especially those who are patients in our state and private hospitals has not received

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the impetus that it should, considering that it is a recognized value of almost the greatest importance in the treatment of mental diseases. While therapeutic occupation for the blind, crippled and other handicapped individuals has made enormous strides the last few years, this form of treatment has made compartively little progress in our institutions for the mentally ill. We might learn much from a study of the methods of Dr. Herbert J. Hall, of Marblehead, who has done pioneer work in the development of occupation for non-mental cases. In a paper read by him in Boston, in 1914, in discussing the subject of special vocational schools for discharged patients from state hospitals, he says:

"It seems to me that we are not ready for outside industries, because we have not yet made full use of the hospital opportunities for industrial or vocational training. The modern state hospital is a little industrial world. Almost all the trades, all the domestic occupations are carried on under its administration." He then cites the various necessary occupations to which patients are already being admitted, with undoubted benefit to themselves and to the hospitals, and continues: "This is a most gratifying situation, but I will venture to predict that it is only a very small beginning. Very much credit is due to the hospital superintendents and their assistants for their accomplishments so far. With an especial force of industrial teachers, however, the labor of the patients could be much more efficiently used, with a greatly increased benefit both to the worker and to the state. It would be far too much to expect that with all their other duties the present nurses and assistants could find the right job for each patient and then get the best and the most efficient work accomplished. But here is a task which must be undertaken if we are to train our patients for successful life outside, or if we are to avail ourselves of the tremendous industrial possibilities latent in the wards of the state hospitals. Here is the opportunity for special industrial teachers—I do not mean teachers of arts and crafts, for the crafts are relatively a small matter and are being developed. I do mean teachers of high-grade, whose business will be to study the individual patient, with the idea of making him highly efficient, not only while he is in the hospital, but later, in any industry which may be managed after his discharge. We shall be much more likely to succeed with outside industries if we have made careful

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vocational study of the individual, if we have tried him out and proved him under the protection of the institution."

I would heartily recommend Dr. Hall's books, written in conjunction with Miss Mertice M. C. Buck, entitled "The Work of Our Hands" and "Handicrafts for the Handicapped."

A comparison of statistics covering the work of a purely therapeutic nature done in a so-called up-to-date group of state hospitals two years ago with the work done at the present time shows very little increase in percentages of patients occupied. Ward work, including the care of rooms, kitchen and laundry, and farm work have increased, but this increase appears along the lines of industry and economics, rather than of therapeutics. Reports do not show that sufficient study is made of the therapeutic application of this work nor of its therapeutic results.

In how many of our state institutions in this country will you find more than a small percentage of the total number of patients being studied along the lines of vocational training and the determination of therapeutic occupation as a means of improvement or cure? To be sure there are classes in many of the hospitals where certain teachers instruct some patients in therapeutic occupation, but they constitute but a very small proportion of the total number of patients occupied in any hospital.

In the face of the recognized value of occupation as a remedial measure in this branch of medicine, and in the face of all that has been written on this subject both in the magazines and in medical publications, it is appalling to go through the institutions for the mentally ill and see the great number of patients who are now as idle as they might have been 50 years ago—many sitting on benches, others loafing about the grounds, and large numbers lying in bed day in and day out with nothing to do.

I know that it is a physical impossibility for superintendents and other members of the staff to set all of their patients to work at once, but every hospital should be so organized that there would be, in addition to expert teachers, a corps of instructors among the nurses and other employees who would in turn extend their knowledge to other nurses, and in addition they should be given a course in therapeutic occupation in the training schools, so that every graduate nurse would be able to carry out prescriptions written by the medical officer for this important branch of treat-

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ment. With such a force in the hospital, the medical officers should either themselves or through the creation of a new office, *i. e.*, vocational trainer, preferably with medical education, to study the needs of every patient, that each one may have some occupation which will help in the treatment, to the end that they may not only be happier in the hospital, but, in many cases, less destructive, less depressed or less noisy, and, what is of great importance, if the patient is able to do something that is useful and of value as a therapeutic measure, he may continue the same occupation after his discharge.

Very often the mistake is made of laying too much stress upon the value of the product of labor of certain patients, because of their efficiency in certain directions before they came to the hospital. Too little attention is paid to the fact that in many instances it may have been that very occupation or employment which contributed to the breakdown; or, that the particular occupation or employment may be accompanied by ideas of environment or influence associated with the illness before coming to the hospital which it might be dangerous to revive. This, of course, is not always the fact, and it is not unusual to find that a patient is made much better by resuming his regular trade or occupation, especially if he finds he can do in the hospital what he was unable to do before coming there.

In hospitals where the percentage of occupation is high, restraint percentage is low, including seclusion and packs. In hospitals where the "open-door" treatment is in vogue, the percentage of restraint, seclusion and wet pack is extremenly low or entirely wanting. For example, at Sykesville, with a thousand patients under the open-door system, there is no restraint.

Members of the staffs of our hospitals, either state or private, should not allow a day to pass without having started one or more patients who had previously been idle, according to the population of the hospital, in occupational work. If a patient is only able to do one hour's continuous work in one kind of occupation in one day, then other forms of occupation should be prescribed after the physician has made a study of the particular case.

Dr. Fernald, in the school for the feeble-minded, has never been satisfied with one hour a day for any patient, and shifts those not capable of continuous effort in one direction from one occupation

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to another, until he has mastered the therapeutic needs of each of his patients along industrial or other occupational lines.

It would seem that enough has been written on the subject of this mode of treatment, but there evidently is something wanting, else our superintendents would not to-day have so many idle patients on their wards. The time has come when no superintendent should be satisfied with a table of occupations showing only six to twelve per cent who are really receiving occupational therapy, with 40 per cent or even 50 with industrial or economic occupation—many of them occupied only an hour or two hours a day, and with the other 30 or 40 per cent receiving little attention, if they are bed patients, or if violent or senile, only such attention as attendants are able to give them by walking them about for an hour or two in the whole 24 hours, and this walk confined to stereotyped paths or routes which occupy comparatively small space of the usually extensive grounds of the institution. Many patients in institutions of a thousand or more should be found who would make valuable teachers, and who would be able to do work under the direction of physicians which would in itself be a therapeutic measure for them, and there might be a certain percentage of these teachers who might continue in the work after recovery. I hope to live to see the day when the ex-patients of the hospital will not be barred from employment in a hospital for the mentally ill. If their treatment has been what it ought to be, if their training in occupational or industrial work has been what it ought to be, instead of being cast out of the door forever when they leave the institution as "improved" or "recovered," certain of them ought to be among the most valuable employees, able intelligently to carry out the instructions of the officers or other employees and to be of great service to their fellow-kind who have need of just the sort of sympathetic care and treatment that might be administered by these very persons under proper direction.

There are many professional teachers of therapeutic occupation now being developed for our general hospitals, and for our hospitals for the blind and crippled. It is not a credit to our alienists that we have allowed other branches of medicine to proceed so much more rapidly in this direction, with the compara-

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tively small proportion of their cases needing this kind of therapeutics, than we have done when almost every individual case requires the most intelligent and judicious administration. We were by many years the first to start, and we should have been the first to develop this branch of therapeutics, and should long ago have been able to supply the needs of the small units requiring such teaching.

A careful study made last year by the Massachusetts State Board of Insanity of the working capacities of the state institutions under their care shows that they had on June 1, 1916 (exclusive of patients boarded out), a total of 17,683 patients, and that the working capacities of the institutions at that date could have provided employment of some sort for 16,456 patients, that is, that we could have occupied 92.54 per cent of our patients, given a maximum of efficiency. Allowing for the number of patients too feeble or too demented to work, this would at first glance seem to be an adequate provision.

As to the use made of this provision, we find that on the same date there were actually occupied, for some fraction of the day, 13,016 patients. According to these figures, and judging *only by figures,* we are 80 per cent efficient. But an analysis of the different types of work actually being done leads one to a very different conclusion.

Excluding the schools for the feeble-minded, Tewksbury and Bridgewater, because a comparison of their figures with those of the state hospitals is hardly fair, we find that on June 1, 72.66 per cent of all patients are reported as occupied. Again allowing for those incapacitated, this seems like a fair showing; but, bearing in mind that the object of occupation in a *hospital* is admittedly therapeutic, let us inquire how far this idea is being carried out.

It is impossible to separate the different classes of work in any such report as this so as to distinguish the strictly therapeutic work from the industrial or necessary work of the institution. Indeed there is no doubt that, with proper classification of workers and careful supervision, domestic and departmental work are very important branches of therapeutic treatment; but there is always the danger, especially under economic pressure and that of short-

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sighted utilitarian public opinion, of relapsing into the old institutional habit of getting our work done along the lines of the least resistance without consideration of the individual patient's interest, allowing patients who are not helpful to the institution to relapse into habits of idleness which retard recovery in some and hasten deterioration in others; and on the other hand running the risk of overworking willing and industrious patients.

An analysis of the state hospital figures is interesting, though not conclusive. It is shown that an average of but 3.03 per cent of their population are occupied in shops and 8.94 per cent in the industrial rooms, making a total of 11.97 per cent of the patients in these more scientifically directed branches of occupation, under special trained teachers. We also find that many of these patients work but a very small part of the day—12.57 per cent work for one hour or less, and 29 per cent of all patients, or about 40 per cent of the total number occupied at all are occupied only in ward work, which one suspects is of very little practical value to the patient as at present organized. For instance an inquiry made by the State Board of Insanity last year to ascertain how many of the patients reported as occupied were merely engaged in swabbing and polishing floors showed that in the various institutions from 1.4 per cent to 14.4 per cent were reported as thus occupied. More or less of this class of work is done by patients in all state hospitals, but where it is the patient's sole employment, it can hardly be qualified as therapeutic, and in many instances it would seem to be dictated by laziness, ignorance or lack of initiative on the part of the nurse.

The Committee of Diversional Occupation of the American Medico-Psychological Association at Old Point Comfort in 1915 awarded "gold stars" to five Massachusetts hospitals on the following points:

1. Having a director of occupational work with assistant teachers.
2. More than 50 per cent of unwilling workers occupied.
3. Industrial work as part of training course for nurses.
4. Industrial Department as well as work on wards.

It is to be hoped that all of our hospitals are now fulfilling these outline requirements, though no just estimate of the efficiency of

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the work can be made in this way. It is quality as well as quantity that counts for real success—we should not only ask how many patients are working, but how many patients are intelligently set to work for their own benefit.

Dr. Clara Barrus, in her most excellent text book "Nursing the Insane," published as long ago as 1908, has a most excellent chapter on occupations. She says: "Nurses need to remember that new patients should not be set to work until their occupation is sanctioned in kind and degree by the physician. I hope the time will soon come when, in addition to the various industrial shops in vogue in some hospitals, there will be regular schools, where the truths in kindergarten methods will be made applicable to patients; courses of instruction adapted to the needs of various classes and conditions will help in upbuilding mental health. I wish to emphasize the necessity for individualization in the choice of occupation, the particular work being suited to a given patient and to the patient's existing condition. Never allow him to jog along from day to day in work which, though it may have been suited to him at one time, is now for any reason no longer adapted to his strength. Patients should be encouraged first of all to do all that they can to help themselves and then to do something each day to help others.

"Up to about 1880 restraint was generally used in this country, leading to much criticism from visitors from abroad who were familiar with the non-restraint methods practiced in English institutions; and from 1850 to 1880 scarcely a meeting of the Association of Superintendents of Institutions for the Insane was held in which the matter was not debated. It was evident that the opinion of the majority of superintendents was in favor of restraint, though an occasional voice was lifted against it.

"Wherever non-restraint was adopted carefully and judiciously it promoted the comfort and well-being of the patient. But where non-restraint was simply decreed without any attempt to furnish a substitute for it, it was found that the relation between the patient and the nurse became extremely unpleasant. The nurse, forbidden to use mechanical restraint, sometimes resorted to force and intimidation, which resulted in personal collisions between the patient and his nurses. Not a few of the earlier attempts at

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non-restraint failed because of this failure to devise occupation for the patients."

That there is a close connection between the absolute abolishment of restraint, the introduction of therapeutic occupations and the higher morale of the nursing force of any institution for the mentally ill is self-evident to any student of the situation. I believe that no efficient work can be done in any one of these branches without affecting the others favorably, and it seems to me that all three points may well be attacked at once.

The more the drudgery of custodial care is diminished and the interest of teaching substituted, the better class of caretakers we shall attract and the fewer we shall need. It has been demonstrated that patients occupied in interesting work need less supervision. We might, therefore, well afford to pay for the higher type of service demanded rather than for a large force of custodians. The resultant economy in the prevention and cure of insanity can never be reckoned in dollars and cents, but it must surely result in a much smaller ratio of increase in hospital population, to say nothing of turning out self-respecting men and women, rather than potential paupers.

I can most heartily recommend a recent book, "Occupation Therapy," by Dr. William Rush Dunton, of the Sheppard and Enoch Pratt Hospital. Dr. Dunton deprecates the informal way in which most hospitals permit their nurses to learn what they can of the occupation of patients merely through observation. He says it is practically impossible for a nurse to gain knowledge of basic principles under these circumstances, and recommends a lecture or two early in the training to open her eyes to this very important branch of her work. He says we must "study carefully to learn what form of occupation is most suitable for our patient, and if no specific directions have been given by the physician, it is the duty of the nurse to do this. The primary purpose of occupation should be to divert the patient's attention from unpleasant subjects, as in the case of one depressed. Or, in a case of dementia præcox, where the patient is given to day-dreaming or so-called mental rumination, occupation is given to direct the patient's train of thought into more healthy channels. In a case of mild excitement, occupation will keep the patient's mind more continuously on one subject than is possible if he has

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not this stimulus to control his attention. In cases of marked excitement it is usually impossible to use occupation in treatment, which is usually directed toward securing rest; when convalescence is begun, occupation will be of value. In cases of dementia of various sorts the object may be to re-educate, to train the patient to develop the mental processes by educating the hands, eyes, muscles, etc., just as is done in developing the child. Another purpose of occupation may be to give the patient a hobby, which may serve as a safety valve and render the recurrence of an attack less likely. Still another purpose, which is less often resorted to, is to give the patient a means of livelihood after leaving the hospital, it being deemed wise to give up the former vocation." "The *mechanism* by which a recovery is brought about has been the subject of considerable inquiry. It may be summed up by the word *substitution* or, if one prefers, *replacement*." Dr. Dunton continues: "The question of rewards is one concerning which it is desirable to have some accurate information, which the nurses can often obtain better than anyone else. Do patients work with more interest if there is some prize offered? What form should this take—should it be some tangible trifle, or should it be the granting of a privilege? These are but few of the questions which have been asked, and which have not yet been answered authoritatively."

It seems to me that any generalization as to payment or reward for therapeutic occupation should depend entirely upon the needs of the individual patient. Ordinarily the occupation should be so attractive to the patient that it would be its own reward. The performance of tasks useful to the institution is quite another question, and one which has never, I think, been thrashed out from the economic standpoint.

Dr. Mary Lawson Neff, to whom the state of Massachusetts owes much for the first year's effort at the organization and systematic development of occupational work, takes the reasonable point of view that because the patient is a more or less efficient worker, the state has no right to require from him full-time services. She holds that the state may have a right to demand half of each day's work as payment for his maintenance (though even this is a mooted question), but that he should certainly have the privilege of working for the other half of the day at something from

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which the benefit comes, directly or indirectly, to himself. Thus kitchen and laundry workers who work eight hours a day would be paid for half of each day's work, enabling them to continue contributing to the family support, even while in the institution, or to earn a little money for personal comforts not supplied by the hospital. But especially this idea of half a day's work would enable the hospital to give certain classes of working patients the benefit of vocational training for a part of each day or to give them time to benefit by purely diversional work or play. Such a plan might mean a temporary readjustment of the state's budget, but in the end it would tend to contribute to a greater efficiency in the work accomplished, to a larger number of cures, less discontent among the workers, and perhaps to less pauperism among the families of the patients, and a quicker readjustment to industrial conditions among recovered patients.

Dr. Dunton recommends that, "a record should be kept of the patient's attendance, manner of work, interest, etc., by the teacher of the particular class attended, and that these records should form a part of the patient's clinical history when discharged, as from them may be derived information of considerable value for the physician. It seems best that these should be in the form of frequent notes and comments, rather than a set form, as in the latter case much may be of interest is lost." He refers to examples given by Miss Field in her paper on "The Effect of Occupation Upon the Individual."

Dr. Neff's year of service in Massachusetts was full of interesting suggestions. Her first special undertaking was to develop an educational exhibit of patient's work. In this exhibition she included not only articles of interest in themselves, of which comparatively few were made at that time, but series of articles showing early and later attempts of patients, and some very pathetic things made from old bones, ravellings, bits of torn clothing, and waste material of all sorts, showing the desire of these people, even without encouragement or suitable material, to *make something* rather than sit all day idle, as was then the custom in some very *orderly* institutions. "The exhibits were selected for their educational value, in order to illustrate as far as practicable all the desirable activities that had actually been carried on in some institution. The articles were classified, labelled, mounted on

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cards, in booklets, and in other suitable ways, and formed into a logically developed whole. This exhibit required a great deal of time and labor, but seems to have accomplished even more than was expected of it. It was visited by considerably more than 2000 hospital employees and visitors from outside the hospitals. About an equal number of patients were taken to see it. Representatives were sent to inspect the exhibit from the Russell Sage Foundation, from Clark University and from Wellesley College." The educational effects of this exhibition were widespread, and it is to be regretted that it was not preserved for its educational and historic interest, which were in many respects greater than the recent exhibits of more artistic and more efficiently organized shop-work, which we enjoy rather for their intrinsic merit than for their therapeutic interest. Unless the matter is continually kept before our eyes, there is great danger of our losing sight of the fact that the patient is our first consideration, and that his cure is of more importance, even from an economic point of view, than the product of his industry.

I would recommend to all doctors in state hospitals Dr. Eyman's paper on "Institutional Stasis," read before the Medico-Psychological Association at Old Point Comfort, in May, 1915; to be read at least once a year, that in spite of all discouragements, they may continue to bear in mind that no scientific work is final. Dr. Burgess, in discussing this paper, said: "Speaking from 40 years' experience, I can say that the greatest trouble is that we think of great improvements we could make if we had the money, but unfortunately the money is not always forthcoming. That, however, should not deter us. The aim of the hospital should be progress. The institution that stands still might as well be wiped out."

Dr. Henry P. Frost, of the Boston State Hospital, in a paper read at the same meeting, said that idleness certainly "breeds dementia and fosters the formation of untidy and destructive habits, as well as bad temper and violence. A program of occupation which stimulates the interest, replaces confusion with order and gloom with good cheer, contributes to the cure of many, and cuts down the cost of supervision and maintenance is well worth the effort involved in its establishment." He continues: "The

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great value of occupation in the treatment of the insane is determined by its infinite variety, adaptable to innumerable individual tastes and capacities, its range from utmost simplicity to stimulating technical exaction, but above all its essential normality, constituting it, for these unfortunates, the natural passageway back to normal life. The diversional feature of the occupation needs to be emphasized in order to obtain the best therapeutic results."

After summing up the various ways in which the patient's work is of value to the institution, Dr. Frost adds: "A further very distinct benefit to the administration is to be noted in the better spirit which pervades the nursing staff when a régime of definite and interesting duties in connection with the industrial program replaces the drear routine of lolling and keeping an eye on a ward full of restless, unhappy, dull and dirty dements." In giving the history of the development of this work in the Boston State Hospital, Dr. Frost adds: "After some success had been obtained in developing the interest and co-operation of the nursing staff and the more intelligent and willing patients, special attention was given to the training of the least intelligent class and to the introduction of safe and suitable occupations in the ward treatment of those with violent and dangerous tendencies, for it was felt that these were the larger and more important fields for really effective work."

In another very interesting and suggestive paper read at this conference, Dr. Britton D. Evans, of the New Jersey State Hospital at Morris Plains, and his assistant, Dr. Frank M. Mikels, say: "The form of work assigned should be consistent with therapeutic indications in each psychosis, the reactive effects should be carefully evaluated by a physician, conversant with the régime of treatment—it should not be left to the haphazard judgment of untrained nurses and attendants. Before work is assigned a careful study should be made of the peculiar complexes of each psychosis, in order that the work prescribed will not militate against the improvement of the patient's mental condition. There is no system so vicious as that which relegates a patient with mental disease to the solitude of a custodial institution, and totally disregards the residual earning capacity of that individual." Again these authors says: "There are instances where the pre-

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scription of a certain kind of work to allay the distressing symptoms of a psychosis will actually entail a waste of material, but there is a compensation for this loss if the prescription of work takes the place of administering drugs, and ultimately there is an actual profit, if the patient eventually becomes a producer of articles which have a greater value than the loss of the materials which he used." . . . . "The value of this method of treatment is in direct ratio to the efficiency of the physicians and instructors, and their personal interest in this form of therapy."

Dr. Floyd Haviland advocates the systematization and organization of occupational and re-educational work through occupational schedules. He says that the best results from an occupation schedule are obtained when all work done in an institution is covered by it. "The ideal general schedule, however, not only provides for work done by patients, but also provides scheduled periods for rest, recreation and exercise."

Dr. Charles E. Thompson, of the Gardiner State Colony says: "The superintendent must have enthusiastic instructors in order to get results. It seems to me that this is the important thing—to stimulate rather than pay patients for work done."

One might continue quoting indefinitely from recognized authorities on this subject. The remarkable facts are that all are agreed as to its importance, and that all the forms of work and play suggested are in practical, successful operation in one or more of our state institutions. I should like to see a more thorough, systematic organization of this work in every state hospital; and especially I should like to see Dr. Brigham's school idea more generally revived in the light of modern educational knowledge.

Our state hospitals might well afford to maintain large "Educational Departments," under trained specialists, to which the majority of the patients should be referred as *pupils*, for mental, occupational and physical training, as prescribed by one or more experts in these lines. These departments should include not only our present occupational and industrial work, but should maintain school sessions, varied by physical culture, music, folk-dancing and other recreations, affording opportunities for the needs and tastes of each individual. Such work could not fail to be of extreme interest to the psychologist, and should furnish scientific material of great educational value.

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DISCUSSION.

DR. RUSSELL.—Mr. President, Dr. Briggs has shown in his paper the value of occupation in mental treatment. Its value to patients suffering from mental disorders has been recognized since the beginning of systematic effort to treat them. We do not, therefore, have to concern ourselves with anything except methods and these have been vastly improved. I think that the foundation for intelligent methods in an institution must be the study of the patient, and it should be understood that the efforts that have been made to improve the study of the patients in the institution have a therapeutic object when it comes to the application of occupations and all kinds of activities in their treatment. In connection with this I would direct attention to a chart to be found in the Bloomingdale exhibit in the special room for institutional exhibits. It is not very conspicuous and may escape notice. It is an effort made by Dr. Lambert to devise a graphic method of informing the nurses or the instructors in occupation in regard to the particular traits of the patient that are to be dealt with. It is an attempt at greater precision in applying occupational therapeusis. You will note that long and short bars are used to indicate traits which require encouragement or repression. The charts are recast at intervals for the guidance and encouragement of the instructors, and of course to a considerable extent must be drawn for each patient.

This chart seems to me to be a contribution to the more precise methods which are needed. It is not a finished product, but is a start which I hope will lead to further work in the same direction.

DR. WOODSON.—Mr. President, some years ago when I was young in hospital work it occurred to me that the best results in this line would be obtained from furnishing congenial employment to our patients encouraging them in caring for the fruits grown on the institution grounds. Our earliest crop was strawberries, and taking these up by the patients occupied two or three weeks, then came the raspberries and in large quantities, then the blackberries. And early in my institutional life I planted out a fairly large orchard of all kinds of fruits in order that the patients might have the fruit and have continued activities; also we had cherries, grapes, melons, peaches, and when our patients were taken out, they wanted to work in the berry patches, they wanted to eat them on the wards, wanted to have the privilege of eating as well as gathering them. Baskets were sent and filled with grapes, berries, apples or peaches, and this furnished not only congenial employment but it furnished efficient aid in gathering the fruits. It was beneficial to the patients, as it gave them the most wholesome food, and one of the ways to have an abundance of fruit was to help raise it; and they thoroughly enjoyed being permitted to raise it. Another part of the institution farm was given to potatoes, another part to peaches, pears and apples. The industrial and manufacturing business they did not take much interest in. It is true they worked at it but they seemed to regard it as a task, in which there was neither entertainment nor congeniality. The man who has a trade does not care about working at it especially in an institution.

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There are many men who are now preparing to give employment of this character to their patients and the different lines will furnish varied opportunities. These employments should be under the direction of horticulturists and agriculturists to direct them. The superintendent may direct them but he has no time to oversee anything but the distinct results in the way of improvement coming from his working patients; and if he is wise he will let his patients do in these various lines what they want to do and from this they will derive a large amount of pleasure and improvement, more indeed than through any other recreation or employment whatever.

DR. BRIGGS.—Mr. President, the object of my paper was not so much instructive as to again bring before the Association what had been done, what is now being done, and to try to stimulate still further the occupational work in a scientific way through the medical heads and specially by appointed instructors and vocational workers. I think occupation should be carried out to the fullest extent and we should not see these latent forces wasted; that the value of this therapeutic agency should be constantly inculcated for full benefit cannot now be achieved without occupation and industry scientifically prescribed.

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A SOCIOLOGICAL, NEUROLOGICAL, SEROLOGICAL AND PSYCHIATRICAL STUDY OF A GROUP OF PROSTITUTES.

By DR. JAU DON BALL and DR. HAYWARD G. THOMAS,
Oakland, California.

The following report is the result of a study of 320 prostitutes in the city of San Francisco, California. This study was undertaken by the Neurological and Psychiatrical and Ophthalmological Department of the Oakland College of Medicine and Surgery, Oakland, California, by Dr. J. D. Ball, Professor of Mental and Nervous Diseases, assisted by Dr. Paul Jerome Anderson, Oakland College of Medicine and Surgery; Dr. Hayward G. Thomas, Professor of Ophthalmology, the same college; and with the assistance of Mr. August Vollmer, Chief of Police, Berkeley, California, and with the sanction and assistance of the San Francisco Police Department. Great credit is due to Chief White of San Francisco Police Department, whose cooperation and interest in the investigation made the work possible, and certainly less difficult than it otherwise would have been.

The investigation lasted during a period of 18 months, from August, 1915, to March, 1917, and was unusual in approach, for the reason that all examinations were made in the houses of prostitution during the "working" hours. This was thought to be the best method, as environmental conditions were normal for the work at hand; the inmates being at their "best" and not under the restraint incident to examinations made in institutions or psychological laboratories in connection with courts. Unusual and detracting environmental conditions and emotional states were thus considered eliminated to a large degree. In all, 45 trips were made; 66 houses of prostitution visited; 270 hours or 33¾ days of eight hours' actual time, spent in interviews and examinations.

The expense of this investigation, including laboratory work, was borne by the investigators.

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The reason for this study being a desire to contribute the data and information so obtained in the hope that it might be of value not only in stimulating similar studies, especially from the neurological and psychiatrical standpoint; but in aiding sociologists and others interested in the great social problem of prostitution to a clearer understanding of a few of its causes. The data obtained are presented for what they are worth, and their value lies in the fact that they are the result of unbiased investigation and examination. No preconceived ideas as to possible results were formed; and the personal equation of the examiner (especially regarding any fads, fancies, or fanaticisms relative to his own particular specialty, had he possessed any such) was eliminated as far as possible.

The facts resulting from careful examinations are thus presented to you without any hesitation or mental reservation. Whatever notions or secret ideas any of us might have held regarding this subject were dispelled by the facts obtained.

Methods of Examination.

The following form was used in this examination. Some very valuable suggestions were obtained from Dr. Healy's *Individual Delinquent.*

Name ..... Race .....
Working name ..... Height .....
Residence ..... Color of hair.....
Age ..... Nativity .....
Color of eyes..... Weight .....
Date ..... Build .....
Examined by .....

Heredity.

Maternal grandfather .....
Maternal grandmother .....
Paternal grandfather .....
Paternal grandmother .....
Father ..... Brothers .....
Mother ..... Sisters .....
Parents related .....
Mental ..... Nervous ..... Epilepsy ..... Bright's disease ..
Diabetes ..... Syphilis ..... Eruptions ..... Cancer .....
Rheumatism ... Chorea .....

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HEALTH HISTORY INCLUDING HISTORY OF INFANCY AND CHILDHOOD.

Diseases of childhood, adolescence, and adult life, especially convulsion or disturbances of consciousness.....
Enuresis ..... Birth ..... Trauma .....
Operations ..... Menses ..... Fright or shock.....
Adolescent instabilities or peculiarities, both mental and physical.....
.....
Comparison of development with other members of the family.....
.....
Somnambulism, night terrors, etc.....
.....

SOCIOLOGICAL EXAMINATION.

Housing and financial conditions in detail.....
Occupation of father.....
Reasons for leaving home.....
Whether raised in city or country.....
Companionship; opportunities afforded by relatively good or bad association
.....
Amusements in detail.....
.....
Opportunities for religious culture.....
Former occupation .....
Occupational opportunities .....
Character of places worked in.....
Married ..... Single ..... Widow ..... Divorced.....
If married, complete history of home life.....
Miscarriages ..... Still-born children ..... Children .....

MENTAL AND MORAL DEVELOPMENT.

School history in detail, with individual's own reaction toward it.....
.....
Education .....
Grade reached .....
Much absence .....
Character of association with opposite sex.....
Use and development of special talents.....
Habits: Drug..... Alcohol ..... Tobacco ..... Sexual.....

ADDENDA.

At what age enter sporting life.....
Reasons for entering sporting life.....
Impulse ..... Comrades ..... Alcohol ..... Poverty .....
Unsatisfied interests .....

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Types of Perverts Met with.

.....
.....
.....

Mental Examination.

Ideation	Hallucinations .....
Judgement	Illusions .....
Sleep	Delusions .....
Attention	Orientation .....
Stories, reaction	Emotions .....
Special memory	Suicide .....
Speech	Stereotypy .....
Ethical questions	Catalepsy .....

Insight (appreciation of place in society) .....

Neurological Examination.

	Right.	Left.	
Plantar	....	....	Superior Tendons.
	....	....	Triceps.
Pathological reflexes	....	....	Biceps.
	....	....	Wrists.
Tendo Achilles	....	....	Scapulæ (Graves).
KK	....	....	Cervical Skin.
Epigastric	....	....	Thyroid.
Heart	....	....	Cranial Nerves.
Teeth	....	....	Lungs.
Deformities	....	....	Sensation.
Status Corpus	....	....	Vasomotor.
Skin	....	....	Atrophy.
Pain	....	....	Gait.
Tremor	....	....	Dermographia.
Joints	....	....	Hypertrophy.

Eyes.

Pupils ..... Fundus .....

General Information.

Accompanied by a sergeant of police in plain clothes, we entered the houses of prostitution where the "madames" were informed of the nature and object of our visit. At no time were we met with antagonism and distrust. Every facility and assistance was

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offered by the "madames," and after the inmates ascertained individually the reason for the interruption of their work, they entered into the spirit of the investigation with a manner most pleasing and willing. Occasionally, however, an individual would be encountered who would be grossly excited or emotionally negative, and it would take considerable time to gain her consent for examination. Where such negativism was encountered, it was usually the result of fear engendered in the individual by either vague rumors concerning our methods or by lies told by those already examined, having as an object to frighten the subject, often as a "joke," or a manifestation of a psychosis. In quieting these individuals we were invariably assisted by their less emotional sisters.

Each examiner had a room where he was alone with the subject. The order of the examination was:

1st. The taking of blood for subsequent serological examination.

2d. History taking, and general sociological and educational examination.

3d. Psychiatrical examination.

4th. Neurological examination.

5th. Physical examination.

6th. Ophthalmological examination.

The reason for the taking of the blood, for serological examination, first, was to eliminate at once the fear of the taking of the blood, which we early found to be a distracting factor if left to the last.

The form above given and used in this investigation gives an idea of the extent of this research. However, many questions were asked which are not included in the form, and were necessitated by the individual cases to obtain a correct sociological and psychiatrical impression.

Also, after the conclusion of the examination of a group for the evening, the examiners would spend at least forty minutes, sometimes an hour, discussing the cases examined. This was especially valuable, as by it they were enabled to digest the impressions of each other regarding the individuals studied.

Of special interest to this organization will be the results of the serological, neurological, ophthalmological and psychiatrical examinations.

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A. Serological Data.

Original Wassermann method was used,[1] occasionally results being checked by other laboratories, all sera being run along with sera from private patients.

Needles were specially prepared and sterilized and placed in specially prepared and sterilized test-tubes until used, the test-tubes being used to collect the blood. Therefore, no boiling of needles was necessary in the houses, each subject having individual needle and tube.

Seventy-four per cent of the total number of 320 had positive Wassermann reaction with blood serum; 3 per cent gave a negative Wassermann reaction; and 23 per cent admitted having had syphilis or were under active treatment for the disease.

B. Neurological Data.

It has been the custom, only too often, not alone by the general physician but also by the neurologist, to pass lightly over a slightly exaggerated or a slightly diminished, or even retarded reflex.

If a reflex is greatly exaggerated, or very sluggish, or absent, it is so recorded. The finer degrees of variation from the normal are seldom recognized and certainly infrequently recorded.

This brings up the question of what is the normal response of a deep or a superficial reflex. In the clinic of the Neurological Department of the Oakland College of Medicine and Surgery, it has been the custom, since 1913, to use an arbitrary method of recording reflexes, as follows:

Normal is considered the reaction as a result of a stimulus applied always in the same manner and with the same degree of intensity; and of necessity, for clinical purposes, must be taken into consideration the personal equation of the clinician.

Experiments have been conducted and time reactions developed for the various reflexes; but as yet the practical application of these methods is distant, especially where time is a factor. Accordingly, a system of recording reflexes ought to be adopted that will at least be more or less universally used, even though the personal equation of the clinician does enter.

For our purposes we have used *N* for normal, and decimals of five up to twenty, either plus or minus, for exaggerated or diminished reflexes, and 0 (zero) for absent reflexes. For example:

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A normal KK in our conception is the response of the jerk to a blow from a hammer always of the same size and weight, and applied always with the same force. By experience it is learned that a jerk of a certain amplitude will take place normally as a result of the application of the stimulus under same conditions.

If there is an increase in the quickness of the response of the jerk to the usual stimulus, this is measured in degrees as +5, +10, +15, or +20 and might be further explained as follows: Slightly exaggerated, exaggerated, greatly exaggerated, and very greatly exaggerated (the latter approaching a leg clonus or the greatest possible increase from the least possible stimulus). If there is a decrease in the quickness of the response of the jerk to the usual stimulus, it is recorded in degrees as −5, −10, −15, −20, or 0, and in language can be designated as slightly diminished, diminished or sluggish, greatly diminished, very greatly diminished, and absent. (A very greatly diminished reflex being the least possible response to the greatest possible stimulus.)

This method can be applied to all of the deep and superficial reflexes, and gives an arbitrary method of recording degrees of responses of the various reflexes.

No originality is claimed for this method except that it was developed in the above-mentioned clinic, and a plea is made for the adoption of some standard for recording reflex data. Later it was ascertained that Dr. Sheldon of the Neurological Department of the Mayo Clinic, in Rochester, Minnesota, was using a similar method of recording his neurological observations. Only he used multiples of 1, 2, 3, 4. Just how long he has been using this method, I do not know.

Ninety-seven per cent of these women manifested either pathological or perverted reflexes or sensory disturbance.

The scapulæ of 270 cases were examined. One hundred and sixty-seven were found to be scaphoid ("scaphoid scapulæ, Graves'"), fifty-three straight and fifty normal.

An exhaustive neurological analysis cannot be made in this report; but enough is given to demonstrate that all syphilitics are liable to perversion of their reflexes, and that not enough attention has heretofore been paid to slight differences in quantity and quality of reflex action, especially in those individuals denying a luetic infection or being unconscious of it; such points as disproportion between reflexes are also often entirely overlooked.

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C. Psychiatrical Data.

From the form used in this investigation, it will be seen that a fair mental examination was conducted.

This examination also considers as far as possible the "make-up" of the individual, and also included the mental status, which was ascertained by leading the individual under examination into a general conversation and gradually drawing out any peculiar ideas or observing deficiency of general intelligence, not here entering into a discussion of the psychological problem of whether an individual may have general intelligence but rather using it to indicate a normal individual, as psychiatrists understand that conception.

By that same method, the degree of mental intelligence was ascertained.

Occasionally a Binet-Simon test was made on an unselected individual and in such cases either feeble-minded or subnormal, were defined.

A friendly feeling was first established between the investigator and the subject under investigation, and as the conversation progressed, a few direct questions were thrown in, and the degree of intelligence, memory for recent and past events, family history, personal history, data of life, general knowledge, such as calculation, writing, retention, were ascertained. Much was learned from the general attitude and manner, facial expression, speech, emotional responsiveness, and replies to ethical questions.

At no time did we find any fully developed major psychoses. However, we did find types such as manic-depressive, dementia præcox, and hysterical.

The number of manic-depressive was small (and the symptoms were mainly brought out when the subject was under the influence of alcohol or drugs, at such time the subject stating she was either greatly excited or severely depressed, more often depressed and suicidal), usually with history of abnormally long periods of mild depression or excitement preceding or following alcoholic or drug indulgence.

The dementia-præcox types were ascertained by eye-ground findings in association with results of general mental, neurological and physical examination.

The number of manic-depressive types so found was 64 or 20 per cent.

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The number of dementia præcox was 123 or 38.4 per cent.

The number of hysterical, 19 or 5.9 per cent.

The remainder, 114 cases, we considered subnormal or defective mentally without manifesting any indications of a psychosis. The number having attempted suicide was 35 or 10.9 per cent. One had attempted suicide three times and one, twice.

D. Sociological Data.

By sociological data we mean particularly sociological causes, if there can be such, of prostitution, with especial reference to this group. Here, we do not assume that the science of sociology treats of "social evils and their remedies," but rather looking at it as Elwood has well stated as "social evils being incidental in normal social evolution."

Nor have we lost sight of the biological aspect of the subject.

NATIONALITIES.

Country.	Number.	Country.	Number.
France	55	Sweden	4
America	49	Irish-American	1
Germany	43	Austria	4
Ireland	30	Poland	3
Jews of all nations	20	Belgium	3
England	19	Denmark	2
Scotland	17	American Indian (half breed)	2
Mexico-Spanish (half breeds)	16	Holland	1
Scotch-Irish	10	Roumania	1
Italy	8	Finland	1
Russia	7	Unknown	19
Canada	5		

By "country" is meant that the individual was born in the country indicated, or the parents were natives of that country.

OCCUPATION OF FATHER.

It is interesting to study the following table of Occupation of Fathers of this group of prostitutes. On close analysis it is found that the largest number of fathers were *farmers* (12 per cent). Next in order we have carpenters (3.75 per cent); then saloon-keepers (3.25 per cent); then tailors and barbers (each 2.5 per cent); then clerks (2 per cent).

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Among the fathers, we find seven physicians; two lawyers; ten each of contractors and tailors; seven each of laborers and railroad employees; six each of merchants, miners, musicians, and steam engineers; five each of stone masons, blacksmiths, and innkeepers; four each of barbers, enlisted army men; three each of grocers, painters, lumbermen, plumbers, electricians, and shoemakers; two each of school teachers, millers, clergymen, brewers, teamsters, jewelers, sailors, mechanics, and civil engineers; and one each of shoe manufacturer, potter, dairyman, salesman, gardener, printer, baker. factory-worker, moulder, bank clerk, artificial flower maker, draughtsman, tanner, bank cashier, peddler, scavenger, architect, government clerk, bookbinder, furrier, chef, broker, piano maker, tent-maker, bricklayer, newspaper reporter, and grain tester. The balance did not know occupation of father or for some reason would not answer.

FORMER OCCUPATIONS.

Former occupations of the prostitutes in this group include the following: Hair-dressers and manicurists, 10; waitresses, 27; hospital nurses, 4; factory workers, 16; housewives, 4; seamstresses, 11; servant girls, 60; stenographers, 16; department-store clerks, 40; telephone operators, 20; artificial flower makers, 7; laundry workers, 13; dance-hall entertainers, 6; milliners, 7; governesses, 3; convent student, 1; barber, 1; chorus girls, 19; high-school teacher, 1.

REASONS FOR ENTERING LIFE OF PROSTITUTION.

The various reasons for entering life of prostitution as spontaneously given by the individuals of this group being:

"Easy money"; "thought her previous sex experience unfitted her for marriage"; "induced by other girls"; "language difficulty"; wanted clothes"; "put in business by husband"; "wanted sexual intercourse"; "did not like to work"; "good time"; "induced by men"; "to support child"; "curiosity"; "excitement"; "easiest way to make a living"; "imagined a gay life"; "fool, I guess"; "mother to support"; "deserted by husband"; "trouble"; "drifted from cabaret"; "thought was pregnant"; "pregnant and discouraged"; "too strict at home"; "induced by prostitutes"; "wanted nice things"; "seduced by employer";

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"wages too low" (principal answer of factory girls, servant girls and clerks); "abuse at home"; "bad company"; "just happened"; "alcoholism"; "in debt"; "knew others in business"; "wanted money."

ASSOCIATES.

One hundred and forty-four or 43.75 per cent stated positively that their childhood associations were bad; 96 stated that their childhood associations were good; eight stated that they had no associates; the remainder stated that they had both good and bad or refused to answer.

AMUSEMENTS.

The various kinds of amusements appealing to this group, both as children and at present are: "Shows"; "dancing"; "roller skating"; "horseback riding"; "theater"; "music"; "fancy work"; "athletics" (several of this group being professional swimming girls); "just fool around"; "Sunday-school"; "parties"; "sewing"; "everything tough"; "eating"; "cafes"; "picking flowers"; "card games"; "picnics"; "dolls"; "excitement"; "reading novels"; "movies".

REASONS FOR LEAVING HOME.

"Dissatisfied with home"; "stepmother" (11); "stepfather" (2); "mother dead" (2); "early marriage" (28); "orphan" (11); "to work" (36); "eloped" (2); "to enter house of prostitution" (9); "family quarrels" (20); "stage struck" (2); "needed money" (5); "to see life" (1); "pregnancy" (10). One at 12 years; one at 14 years; two at 15 years; one at 16 years; remainder older; "deserted by lover" (8); "direct from home" (9); "wanted to go to city" (9); "too large family" (1); "ran away" (11); "induced to leave by another girl" (1); "adoption" (1); "bad company" (18); "poor home control" (1); "alcoholic father" (1); "to better herself" (1).

OCCUPATIONS OF MOTHERS.

Housewives; cooks; waitresses; trained nurse (1); dressmakers; clerks; laundress; boarding-house keepers; prostitutes (4); physician (1).

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FINANCIAL CONDITION OF PARENTS.

Seventy-one stated parents were very poor. Remainder stated parents were either in fair financial condition or provided well for their families. On being asked what they meant by being well provided it was ascertained homes (either farm or small homes in cities), plenty to eat and decent clothes. None stated parents were wealthy.

EDUCATION.

Sixteen per cent entered first year of high-school; 46 per cent reached sixth grade; remainder gave definite evidence of being defective or subnormal. By subnormal we adopt Dr. Healy's conception of subnormal.

AGES OF FIRST SEXUAL EXPERIENCE.

It will be noted that the greatest number of inmates had their first sexual experience between the ages of 14 years and 18 years.

AGES AT WHICH ENTERED SPORTING LIFE.

Here it is observed that the greatest number enter the life of prostitution between the ages of 17 years and 22 years.

The graphic charts show this very well.

No attempt is here made to further analyze these figures except to mention that in a large percentage of juvenile delinquents improper sex experiences occur.

E. Ophthalmological Data.

The ophthalmological examination was made to check up the work on optic neuritis done by one of us (Thomas) as per published article in the American Journal of Insanity, July, 1915, "Optic Neuritis and the Color Fields in the Diagnosis of Syphilis, Hyperthyroidism, Neurasthenia, Dementia Præcox, Manic-Depressive Insanity, and Third Generation Syphilis."

The claim was made that many optic discs were classed as normal which were distinctly pathological, the principal point in the disc being the filling up of the normal excavation. This was found out by accident in noticing optic discs which had, when first observed, no excavation, and under treatment the excavation had reappeared.

Any toxic condition may produce this condition of filling up of the disc, and it is also noticed that the condition and degree of

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filling up, or swelling or cloudiness, changes from time to time, changing in intensity, as the patient may absorb or get rid of toxines. This may mean any infection, intestinal, appendicial, etc., tonsil or teeth infection, mineral poison, or most often syphilis.

The condition of the optic disc is a fairly reliable barometer in judging the condition of the nervous and circulatory system, the color or swelling of the discs and also the condition of the vessels whether the veins are dilated little or much and tortuous or angular and whether the arteries are tortuous or not.

Tyson and Clark in the Archives of Ophthalmology, July, 1912, published a résumé of their studies of 109 cases of optic discs and vessels of dementia-præcox cases and give their summary as follows:

1. Congestion of discs; hyperemia and œdema; dilated and dark-colored veins; slightly contracted arteries, and blurring of the edges of the discs, all varying in degree. These changes constitute a low degree of perineuritis of the optic nerve.

2. Congestion of the nasal side and pallor of the temporal side, dilated veins and contracted arteries.

3. Pallor of the discs, dilated veins and contracted arteries. These changes constitute anemia and partial atrophy of the optic nerves. The more marked changes in the eye-syndrome were found in the more rapidly deteriorating types of dementia præcox.

In all these types (see chart) will be found various degrees of filling the Porus Opticus or the " P. O." for short. In Nos. 1 and 2 we may see a tiny dot of a P. O., or absent in one and hazy in the other. In the third variety there is rarely any sign of excavation; they are pale, yellowish pale, like a full moon on a slightly hazy night, and doughy. The condition has the appearance of a beginning atrophy, but atrophy is rarely seen. We have tried to distinguish them from the active neuritis cases; and in examining these cases the classification has been borne out by the neurological and physical examination. Many discs partake of both an active inflammation, with the D. P. type of disc. Many are border line. During the examination the neurologist would hazard his opinion as to the variety of discs the case would have and the ophthalmologist the variety of cases; whether " D. P." type or active syphilis, or the near-tabetic. We found the judgment on both sides was in the great majority of cases correct. We speak of the " D. P." type of discs; we find this classification covers the feeble-minded,

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imbeciles and idiots as well, and as all these cases are similar, merely a matter of degree of deterioration, they also blend one into the other and all classes have their "border lines."

The pathology of these cases has been corroborated by Dr. Myrtelle Canavan,[8] pathologist to the Boston State Hospital for the Insane, in her report of 58 cases of optic nerves examined, unselected. Forty had definite optic neuritis, and 18 of the 40 showed evidence of syphilis.

Dr. Clinton T. Cooke,[9] of Seattle, Washington, also made an ophthalmoscopic examination of 150 dementia præcox and manic-depressives, a tabulation of which he presented at the Portland meeting of the Pacific Coast Oto-Ophthalmological Society in June, 1916.

His findings are a corroboration of the findings of Tyson and Clarke quoted before, and of Dr. Thomas's statement. Dr. Canavan's pathological findings certainly put the finishing word to it.

PUPILS.

SIZE.

Normal.	Large.	Small.	Irregular.	Unequal.
227	27	13	13	10

REACTION.

Normal.	Sluggish.	Absent.	Hippus or "Clonus".	Argyll Robertson.
189	72	5	4	3

EXCAVATION OR "P. O."

Present (in any degree).	Absent.	Present in one, absent in other.
103	159	38

OPTIC DISCS.

D. P. Type.	Neuritis.	Negative.	Atrophic Appearance.	Papilloedema.
123	97	59	10	5

Nystagmus noted in three. Strabismus noted in three.

F. Psychological Data.

Under this caption we attempt to give the result of our observations extending over a period of 18 months. In other words, an attempt will be made to give you the same perspective as we have.

Looking back over our work of a year and a half, it is with no little difficulty that we set down our impressions of the social prob-

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lem of prostitution. The work extending over such a period of time, and visiting such a large number of houses, tended to wipe out all preconceived theories and notions about the subject. All these theories and notions in the popular mind arise from lack of knowledge and the hysterical and misleading statements sent out by well-meaning, but misinformed, enthusiasts, who, by edict, would make the world over in a night.

It particularly strikes us that everywhere the laws are directed against the woman. Granted that the women are unchaste, fallen, and undesirable in a community; it is the men who seek them out, and it is easily 20 to 1, as not only our figures, but the statistics of others, demonstrate. Also that at least one-half of the visitors are married men.

If the problem of prostitution is to be attacked, something more will have to be done than chasing or shooing these unfortunates from pillar to post.

If you could have observed those streets and alleys by night as we did and have seen the army of men trailing up and down, in and out, like at a fair, it would illuminate the subject a little more.

The observations made inside the houses would also change your notions. Pitiable, yes, pitiable; for usually it meant simply young girls from homes of no training, of no innate strength of character, of little or no education, giving history of poor, often extremely bad, environmental conditions, of poor heredity, bad associates, the majority testing subnormal, many defective and feeble-minded and manifesting few or no special abilities, and many disabilities.

The especially educated, gifted, witty and sparkling ones, it was not our fortune to meet. We read of them, but seldom are they seen in houses of prostitution. They may be "kept women," and we hear of them in divorce and probate courts. We found no places where girls were kept against their wills, as most of the houses we visited were the so-called "cribs," nobody living in them except the "madame," the girls all having lodgings elsewhere and coming to work at certain hours and working under assumed names.

The term "white slave" is a very flexible one, and in the public mind is synonymous with all that is associated with prostitution. Certainly, in San Francisco, the police have kept pandering to a minimum, and unwilling detention in a house of prostitution is

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unknown, certainly, as a practice. No woman ever enters this life at the point of a pistol. The prostitute's life is usually easily deciphered, and we find the following picture the usual one: "Sexual experience" (sometimes numerous) preceding the actual "turning out"; "the decision to offer her body to indiscriminate intercourse with men for hire"; "the gratification of her ambition"; "the entering a house of prostitution and becoming a part of the 'system.'" These women are the ones who in the shuffle of life dropped into their respective places as the various-sized oranges or pieces of crushed rock dropped through the apertures in the grader into their respective receptacles.

Their equipment is not sufficient to enable them to cope with any environment in a normal manner.

This is not alone a sociological problem but a psychological problem as well, and the studies of causes should begin in the cradle—the individual, male and female, should be studied, and those having special abilities should have them developed; those early manifesting bad sex habits should be guarded and if defective should become institutional cases.

A plea, then, for closer studies of our school children, an establishment by either public or private funds, of psychopathic laboratories for this work.

Conclusions.

Realizing that in our present state of educational and social development that a demand exists for prostitutes and that so long as the demand lasts, the supply will somehow be obtained, education, and proper early segregation of socially unfit of both sexes will be the ultimate solution if it can be called such. At present a vicious circle exists.

"As an economic, sociologic, eugenic, and medical problem, syphilis is occupying considerable attention at the present time. The source from which most of the syphilis originates is the house of prostitution. It is a place where syphilis is concentrated." It injures the germ plasm and offspring are often defective, again supplying the individuals who in turn become mere carriers for the spirochæta.

The facts as presented in this paper can be correlated into the following:

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To our minds they demonstrate the close unity between psychiatry and sociology, between venereal diseases and defective offspring; also that associated with syphilis we may have many perverted neurological symptoms hitherto overlooked; also that education, eliminating prudery, is essential to eliminate this evil. At the same time prophylactic measures should be more energetically taught to prevent spread of venereal diseases.

OCCUPATION OF FATHERS.

Occupation.	Number.	Occupation.	Number.
Shoe manufacturer	1	Brewer	2
Stone mason	5	Policeman	2
Grocer	3	Architect	1
R. R. employee	7	Clergyman	2
Potter	1	Scavenger	1
Blacksmith	5	Miller	2
Civil engineer	2	Peddler	1
Dairyman	1	Bank cashier	1
Salesman	1	Gov. clerk	1
Carpenter	15	Bookbinder	1
Mechanic	2	Furrier	1
Painter	3	Chef	1
Merchant	6	Broker	1
Baker	1	Piano maker	1
Sailor	2	Tent-maker	1
Clerk	8	Bricklayer	1
Jeweler	2	Reporter	1
Gardener	1	Farmer	48
Teamster	2	Saloon-keeper	13
Factory worker	1	Innkeeper	5
Moulder	1	Barber	4
Bank clerk	1	Contractor	10
Artificial flower maker	1	Grain tester	1
Maker	1	Engineer (steam)	6
Draughtsman	1	Miner	6
Nurseryman	3	Tailor	10
Electrician	3	Attorney	2
Plumber	3	Physician	7
Army	4	Musician	6
Lumberman	3	Unknown	140
Tanner	1	Teacher	2
Shoemaker	3	Printer	1
Laborer	7		

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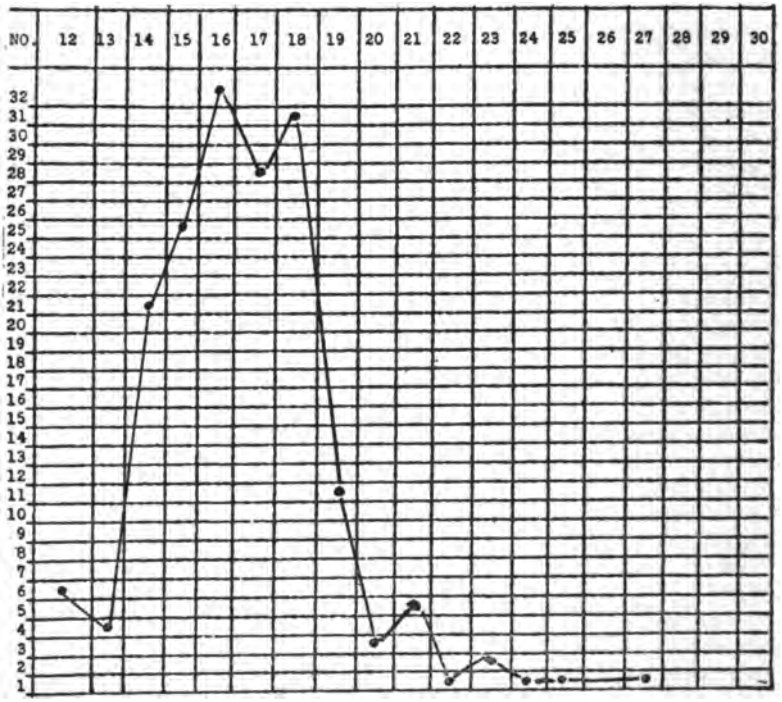
AGES.

Ages.	Number.	Ages.	Number.	Ages.	Number
21	4	29	20	36	3
22	22	30	15	37	2
23	38	31	19	38	2
24	37	32	4	41	1
25	29	33	9	44	1
26	31	34	10	45	1
27	24	35	3	47	1
28	16				

AGES AT WHICH FIRST SEXUAL EXPERIENCE OCCURRED.

Ages....	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27
No.....	6	4	21	25	32	28	31	11	3	5	1	2	1	1	0	1

178 gave ages. Others either refused or did not remember.



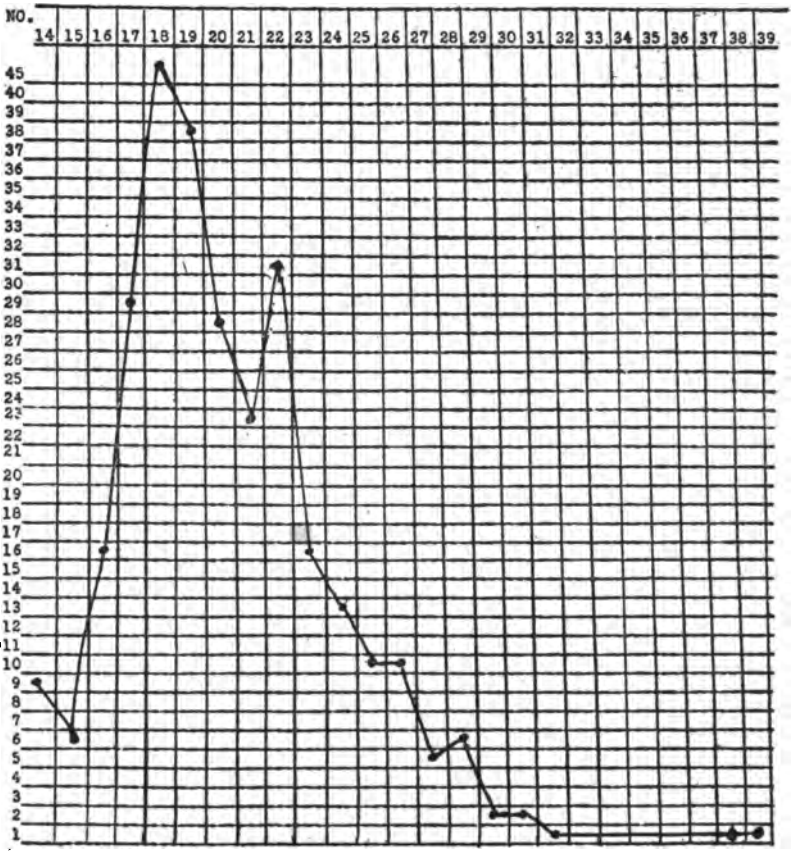
AGES AT WHICH FIRST SEXUAL EXPERIENCE OCCURRED.

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AGES AT WHICH ENTERED "SPORTING LIFE".

Ages	14	15	16	17	18	19	20	21	22	23	24	25	26
No.	39	6	16	29	45	38	28	23	31	16	13	10	10

Ages	27	28	29	30	31	32	33	34	35	36	37	38	39
No.	5	6	2	2	1	0	0	0	0	0	0	0	1



AGES AT WHICH ENTERED "SPORTING LIFE."

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PSYCHIATRY AND THE PROBLEM OF FEEBLE-MINDEDNESS.

By W. B. CORNELL,
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Fifteen years ago, or thereabouts, the practice of psychiatry was almost entirely confined to institutional work. From this intramural, asylum type, this branch of medicine has expanded remarkably.

But, in spite of this expansion, psychiatry has been a laggard in taking up the subject of feeble-mindedness. One index of this is the comparison of the ratio of the medical staff to the number of patients in the state hospitals for the insane with that in the state institutions for the feeble-minded in New York. In the former, the ratio is about 1 to 170, while in the latter it is about 1 to 400; and what is true for New York holds equally for the balance of the United States.

The smallness of the medical staff in the institutions for the mental defective precludes the probability of any medical work or medical organization, as in the majority of instances there is only one physician besides the superintendent, which indicates that the care of the inmates is merely custodial, combined, as may be, with more or less educational effort.

There is no doubt that a survey of the institutions for the mental defective in this country would show a startling lack of medical and scientific work, no medical records, and little or no medical view-point. Even the institutions of highest repute are equally lacking. The best institutions of to-day are those that have best handled the pedagogical and industrial side of the work, but the best ones of to-morrow will be those that embrace the highest type of medical as well as educational work.

The movement for separate institutions for the feeble-minded is a very recent affair, and up to date very few states are so provided.

We find in other states the mental defective in the hospitals for the insane, in almshouses, in other miscellaneous institutions, or

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at large. An appreciable number have undertaken the care of the epileptic in the same institutions with the feeble-minded—a method which, I need not say, is distinctly bad for the epileptic and should be condemned.

There has developed a most remarkable public interest in the subject of feeble-mindedness. This no doubt dates from the beginning of the use of the Binet scale at Vineland by H. H. Goddard somewhat less than 10 years ago. The application of this scale provided an apparently easy method of measuring mentality and, with statistics following in short order, there arose a great popularization, and, as some would say, an exploitation of the feeble-minded.

The pioneers in the new examinations and tests for feeble-mindedness were the psychologists. The extent to which this class of workers have become interested in the subject, Dana shows in a recent article entitled, "Psychiatry and Psychology" (*Medical Record,* February 17, 1917). In 1903, out of a total of 2122 psychological contributions, there were 22 per cent devoted to social and applied phases, while in 1915, out of 2634 titles, there were 62 per cent.

We have witnessed the rise of various offshoots from this new psychology, such as psychopathology, biological psychology, psychobiology, economic psychology, pedagogical psychology and clinical psychology, not to mention others that do not so directly apply to our subject.

Following the psychologists came the pedagogical group, and a large number, occupied more or less in the teaching of the mental defective, became interested not only in developing teaching methods but in examining and testing cases.

Next in sequence comes the social-worker group, who have arduously and assiduously followed the lead of the psychologists and pedagogues and have attempted to carry into practice their various theories and dicta.

Of these three groups, we need especially to deal with the clinical psychologists. These people seem to think themselves peculiarly equipped to carry on mental testing; some go further and make diagnoses and others even venture to make physical examinations. Treatment is the next step, and, behold, we have the

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practising clinical psychologist, a new species noticeably frequent in the fauna of New York. Sometimes these people are rather intolerant of medical men and feel that the latter are bulls in the psychological china shop. A reflection of this is shown in Augusta Bronner's article entitled, "What Do Psychiatrists Mean?" (*Journal of Nervous and Mental Diseases,* August 16, 1916.) Miss Bronner's contention is that certain Chicago medical men, referred to as psychiatrists, seem to have no idea of the accurate use of diagnostic terms in the subject of feeble-mindedness. The gist of her article is expressed in her query: "Is it not time that every physician who undertakes the diagnosis of mentality feels it his duty to know something of general and applied psychology?" To this I would answer "Yes," but also ask: "Is it not time that every psychologist who undertakes to investigate, measure or examine the mentality of the abnormal be required to be also a physician?"

This psychologist group has had and still has a strong following. They have been responsible for much bad statistics and have indulged in much scare-head literature, liberally parceled out to the public. They are responsible for the subject of feeble-mindedness becoming a problem. They assure us, on the basis of a certain ratio, that there are so many thousand feeble-minded in the community who are not in institutions and that all should be permanently segregated or the race is in danger. They have in general given the impression that feeble-mindedness is a definite, uniform condition or, according to Goddard, a unit characteristic and transmissible as such.

It seems it is only by a process of *vis a tergo* that psychiatry is turning more to this subject which is particularly its own. It is more and more realized that the causes underlying and producing the various grades of mental deficiency may be very, very many, and that the study of these causes and their treatment is rightly the province of psychiatry. But this is not being gained without opposition of the clinical psychologists, and probably in no place is this opposition so strong as in New York City.

The institution for the mental defective is a hospital and should therefore have medical supervision. The few remaining instances where there is lay supervision is an encouragement for the clinical psychologist group to seek control of others.

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There is great need at this time that psychiatry awaken to the urgency of the situation. New institutions for the feeble-minded are being projected, built and organized. It is essential that properly trained medical men take the lead in the new movement.

The institution for the feeble-minded should be organized along the lines of the best psychiatric hospitals. There should be a sufficient medical staff and provision for first-class work along medical, surgical, pathological, psychological and clinicochemical lines. The training, industrially and scholastically, should be based upon psychological findings, and, in the adaptation of practical psychiatry to the best application of work, play and scholastic training, the physician should take the initiative. There has been very little of this in the past, but there will be more in the future; the physician must interest himself in all sides of the question.

Scientific medical work in the institutions for the mental defective is the answer to the so-called problem of feeble-mindedness, as it will be likewise to the clinical psychologist and other lay groups. It is up to the medical profession, and especially to the psychiatrists, to carry this through. Recent signs are encouraging, particularly in New York, but more young medical men should be interested and encouraged to take up this work both in and out of institutions.

The opportunities are great and the results obtainable are far-reaching and of inestimable value. There is great need of balance, common sense and experience in working out the problem, but first of all the psychiatrist must become more keenly alive to the situation.

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EUGENICS: ITS RELATION TO MENTAL DISEASES.

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Eugenics may be defined as the science of race improvement through the application of the laws of heredity. In the words of Sir Francis Galton, who laid the foundations of this science in the year 1865, "Eugenics is the study of the agencies under social control that may improve or impair the racial qualities of future generations, physically, mentally and morally. The aim of eugenics is obviously the production of a more healthy, more vigorous, more able humanity and to bring as many influences as can be reasonably employed, to cause the useful classes to contribute their full proportion, or even more than their full proportion, to the next generation and to cause the useless vicious and constitutionally diseased and degenerate classes to contribute less than their proportion to the coming generations."

Both the study of eugenics and heredity must be predicated on some consideration of the origin and evolution of the human race. Whatever may have been the origin of the race, whether from ultimate protoplasm or otherwise, racial evolution physically, mentally, and morally during thousands of years, as related to the study of human heredity and eugenics, is of absorbing interest. We know how slowly but triumphantly this complex evolution has gone on, until man and his achievements, notwithstanding human defects and limitations, during the present and recent centuries have become marvels of efficiency.

Eugenics may be spoken of medically as a prophylaxis or preventive against the continuation of race impairment. As all prophylaxis or preventive medicine is necessarily correlated to the treatment of all racial ills, it follows that we as physicians and psychiatrists may well concern ourselves with the solution of every practical phase of this whole problem as it exists to-day, due to the neglect of eugenic rules, emphasizing particularly the problems here involved of a vast number of preventable mental and other diseases.

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The laws of eugenics are based on the laws of heredity, but the application of these laws is different in eugenics. As underlying the laws of heredity we shall merely refer to some of the conclusions of "natural selection" and "survival of the fittest" as an essential factor in the origin of species and of other related laws of evolution as laid down by Charles Darwin, Alfred Russell Wallace and others, remembering as Darwin says, that this doctrine forms the only rational explanation of the laws of the gradual development of the innumerable forms of living things and their enormous powers of increase.

The Darwinian law of "the survival of the fittest" is greatly modified in the human race because mankind is exclusively possessed of intellect, which Alfred Russell Wallace, the contemporary of Darwin calls "the influx of some portion of the Spirit of the Deity, a living soul, into man, which enables him to conquer in the struggles of life and to help himself and others in dangers, prostrating illness and in providing food, shelter and comforts, in circumstances where the lower animals could not thus provide. Our modern hospitals and other charitable, educational, protective, and humane institutions for conserving the life and welfare of all, particularly the helpless, and for the development of the higher mental and moral faculties, are a sublime illustration of how man's intellect and moral nature differentiates him from the lower animals."

To develop and extend these high human standards of Wallace, it is necessary to remedy the unchecked, blind workings of the laws of "natural selection" by what might be called "artificial selection."

In connection with the laws mentioned and the parent sciences of eugenics, namely: biology and sociology (to which latter reference will be made later), and as fundamentally related to heredity and eugenics, let us refer briefly to some processes in reproduction and embryonic life, and show how the splitting into doubles of the chromosomes in the process of fertilization of the female egg by the male sperm-cell and the consequent mixing of the chromosomes of the parents result in a mixture of parental traits and characters, these chromosomes being termed the determiners of heredity, which carry to the offspring the parental qualities, through the mechanism of the nuclear divisions of the sex cells. This mixture

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of the nuclear chromosomes, called amphymixis, probably has other important functions besides that mentioned, creating variations, particularly the larger variations called mutations, which "natural selection" could take hold of; it also has the function of eliminating certain variations which are possessed by only one parent, constantly tending therefore, to bring the individual progeny back to the type of the species.

Dr. C. B. Davenport, who has contributed largely to this subject, in his several books on "Eugenics and the Laws and Methods of Heredity in Man, the Lower Animals and the Vegetable World," lays down important generalizations, the first of which is "When a determiner of a characteristic is absent from the germ-plasm of both parents, as proved by its absence from their bodies, it will be absent in all of their offspring, this being called nulliplex. Therefore, in order to predict the result of a particular mating, it is necessary first to know which similar unit characteristic both of the parents lack, which they both possess, and whether the characteristics are due to the presence of a determiner or to its absence. This can, in part, be determined experimentally or inferred from pedigrees." It follows, according to Davenport, that we do not inherit from our parents, grandparents, or collaterals but that related individuals have some common characteristics because developed out of the same germ-plasm with the same determiners. "A child," says Davenport, "resembles his father because he and his father are developed from the same stuff." Both are "chips from the same old block." Some determiners carry characteristics that are positive and others characteristics that are negative, which latter depend upon the absence of a determiner. Thus the presence of brown eyes depends upon an enzyme that produces the sepia-colored pigment, while blue eyes depend upon the absence of such an enzyme. It is not always easy to say in advance whether a given characteristic is positive or negative, as for instance: the long hair of angora cats, of sheep, or guinea-pigs is apparently not due to a factor added to conditions that would produce short hair, but rather to the absence of a determiner that stops the growth of hair in short-haired animals.

If one parent has the characteristic simplex and the other duplex, then half the offspring will have it simplex and the other duplex. The inheritance or non-inheritance of some of these traits like hair,

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the color of the eyes, etc., which so well illustrates the precision of the modern science of heredity, though originally considered to be immaterial to well-being, are important, if the observations of Major C. E. Woodruff, that pigmentation protects individuals from the injurious effects of the tropical sun's rays are true.

The combinations or blending of these characteristics is so complex, and has such an infinite variety of results to the human being growing from the fertilization of the ovum (a fertilization that leads to but one out of thousands of possible combinations) there is a plain duty to all who may become parents, to keep themselves in the best possible condition physically, mentally and morally.

The germ-plasm or germ-cells are differentiated from the body or soma cells very early in the course of development and reside in the ovaries and testes, being in a measure out of relation to the body cells and leading a relatively independent existence, except for the fluids surrounding them and from which they derive nourishment. This gives rise to the theory of the continuity of the germ-plasm, meaning that they, the sex cells, carry on through all generations the purely heredity factors, from individual to individual, practically uninfluenced by what may occur in the body at large, so that regardless of such accidents to the body, as for example, the loss or mutillation of a limb, or other similar changes or the acquirement of some special skill in one direction, the germ-cells are uninfluenced and carry on from generation to generation only what they originally contained.

The inference from this theory of the continuity of the germ-plasm is that characters acquired by individuals in their lifetime, or characters possessed by the individual but not inherited by them cannot be transmitted. Weismann and his school insist that the inheritance by the offspring of the acquired characters of the parent is inconceivable. They admit that the germ-plasm itself possesses all the marvelous potentialities which is necessary to account for the highest development of mankind. If Weismann is right in his contention that no acquired characters can be transmitted to posterity, then all of the achievements of our education, training and civilization, which have been going on during thousands of years and which have been so rapid in their strides since the invention of the printing press, are completely lost, so far as they affect the innate character of posterity. While all authorities

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agree with Weismann that the so-called innate or inborn traits are sure to be transmitted, many authorities believe that the effects through many generations of all these acquired characteristics so react on the body and mind and moral nature of human beings that they result in corresponding variations, which have commenced long ago, as a consequence of these forces.

The Lamarckian theory insists that structures came into existence or went out of existence by the results of use or disuse and that the effects in either case were transmissible by inheritance.

The Neo-Darwinian theory, as stated by Dr. William A. White, who has contributed so much of value to this whole subject in the two volumes on "Mental and Nervous Diseases" edited by him and Dr. Smith Ely Jelliffe, explains the effects of use and disuse only as bringing out or suppressing certain potentialities. The muscles of the blacksmith's arm grow larger by use, but they could not grow larger as a result of use if there were not resident within them the potentiality to increase in size, and it is this potentiality, the Neo-Darwinians would say, that is passed on in the germplasm and nothing more. Such changes as the unusual growth of the muscles of the blacksmith's arm, however, should not be lost sight of as evidencing the very material way in which the individual may be influenced.

"Natural selection," says White, "takes place only in the face of selective agents, which are widely distributed and lethal. A disease to which any given portion of the human race is pretty generally exposed, either kills off everybody or else a certain proportion who are subjected to it live, and these are the selected ones who possess some qualities that make them able to withstand the disease. These people breed and reproduce their kind. All those who were susceptible to the disease were killed off, and the result is a race for whom the ravages of this particular disease have no terrors. This is the method of operation of 'natural selection' by the 'survival of the fittest.'

"The phenomena which are explained by imperfection of dominance, patency and latency and degrees of recessiveness have been explained by Weismann by transferring this struggle for existence from the environment where it is usually thought of, to the determiners within the germ-cells. And this theory of germinal selection is that the various determiners of the germ-cells are not all

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placed exactly in the same relations to the stream of nutriment. The inbalance thus created tends to increase those that gain a slight advantage by virtue of that very advantage gaining greater advantages, and obversely for those that are placed at a disadvantage."

One of the most absorbing features of the study of eugenics and heredity is to follow the inheritance by children of the infinite variety of mental, moral as well as physical traits of their ancestors. This brings us to that phase of the subject known as variations from type, which has already been referred to in the mixing by the chromosomes in the germ-plasm.

Variations or modifications must be what is called determinate and not haphazard, as nothing in nature may be assumed as occurring, except in accordance with natural law. The variations caused by the presence of poisons like alcohol or diseases like syphilis, or the stunting effects, during embryonic life, of the lack of proper food, constitute a variation from the type entirely different from those variations here referred to as being determined by the mixing of the parental chromosomes or determiners.

The determination of variations by environment, religious and moral training, and all the educational and civilizing influences during thousands of years form an interesting part of this study as to the exact effects of which the highest authorities have radically differed, as has been pointed out in the brief reference to the theories of Weismann, Lamarck and the Neo-Darwinian theory.

The Mendelian theory of inheritance is based on the conclusions from experiments with plants chiefly, that there are certain characteristics of the individual called unit characters which are represented by the determiners of the germ-plasm, these being conceived to be definite material entities carrying special characters that cannot be blended when used in the true sense of that term, but must be an inheritance dependent upon the segregation and grouping of the determiners. Mendel formulated to the satisfation of his followers with mathematical precision the ways in which inheritance would manifest itself by determining all the possible combinations in which these determiners would group themselves. In studying the Mendelian law it is essential to remember that certain determiners are dominant and certain others are recessive;

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as for example, if a flower contained a determiner for the red color and a determiner for the white color and the red determiner was dominant, the color would be red but if the germ-plasm contained a white determiner which is recessive, this recessive determiner, white, would produce a certain number at least of white progeny. If a given determiner comes from one parent only, the heredity is simplex, while if it comes from both parents it is duplex. If there are no determiners on either side for a given quality it is absent and the heredity is said to be nulliplex. Theoretical expectations and actual findings as related to the Mendelian theory, do not, as is to be expected, always show an exact correspondence but are an expression of probable chance.

One of the interesting conclusions of Mendel is that a pure bred may be derived from a hybrid in one generation, and that the hybrid of a pure bred produced by a long series of hybrid individuals, is just as pure as the pure bred which has never had a hybrid ancestry. Another important consequent is, that among the offspring of the same parents some individuals may be pure bred and others hybrid. Community of parentage does not necessarily denote community of characteristics among the offspring.

Among the high American authorities, who have made valuable contributions supporting the idea that the Mendelian proportions obtained in the inheritance of epilepsy and feeble-mindedness, are Weeks and Davenport in their notable work on "Epilepsy and Feeble-mindedness," and in which they present research and a large number of pedigrees well worthy of the serious attention of students of this subject.

It must be borne in mind that Mendel's interesting experiments were confined to the hereditary manifestations in flowers and plants and certain of the lower animals, and that while they are full of suggestiveness they did not go far enough to justify us in saying that all of his conclusions were applicable to heredity in human beings. Bateson, a leading English authority, says of the Mendelian theory that "we have the certainty that it extends far and that there are ample indications for supposing that we should probably be right in assuming that it covers most of the features whether of the mind or of the body": but he doubts if the Mendelian proportion exists as applicable to the inheritance of

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mental and other diseases. F. W. Mott to whose great work we shall refer later, expresses substantially the same view.

In harmony with the Mendelian experiences are the following lines from Goethe:

"Stature from father and the mood
Stern views of life compelling;
From mother I take the joyous heart
And the love of story telling.

"Great-grandsire's passion was the fair,
What if I still reveal it?
Great-grandmam's pomp and gold and show,
And in my bones I feel it.

"Of all the various elements
That make up this complexity,
What is there left when all is done,
To call orginality?"

Goethe's version of his own traits derived from inheritance suggests that the characters from either parent exists side by side, like the single units on the ordinary mosaic or tiles in a tiled floor.

Galton's "Law of Ancestral Inheritance" has distinct reference to the mechanism of the final splitting up of the chromosomes and their union (not blending) with corresponding portions of the opposite sex, so that each new germ-cell contains chromosomes, some of maternal and some of paternal origin, each with its contained determiners, or the transmitters of each separate character of one parent or both parents. This law, which is satisfactory as a whole, was formulated by Galton, not to apply to individuals, but to express the general result when applied to a large number of individuals in many generations and it holds true only if we consider the chromosomes as being uniform in structure and the part going to form each nucleus being equal not only in quantity but quality. Galton showed that the older and more fixed a characteristic is, the more liable it is to the law of "filial regression." Galton's law compared with Mendel's applies only to masses of people and not to individuals. Galton said "though one-half of a child may be derived from either parent yet the child may receive a heritage from a distant ancestor which neither of his parents possessed. Galton's statistical inquiry into good and bad tempers shows that the determiners were arranged in such a way that there

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resulted both good and bad tempers at haphazard in a family; another arrangement tends to assimilate them in such a way that they shall be all good or all bad; a third set tends to divide families into contrasted portions.

The approximate formula of Galton and others for the inheritance of ancestral qualities, stated briefly is that a man inherits his qualities: physical, mental, and moral—one-fourth from each of his parents; one-sixteenth from each of his grandparents, and one sixty-fourth from each of his great-grandparents; and it has been well said by David Starr Jordan that the one remaining eighth in the final make-up of a man comes from "an unknown and certainly negligible part of the gain through the father's activity; an unknown and negligible part of gain through the mother's activity; an unknown part, fortunately also negligible, of loss through the idleness or non-development of each; an unknown and doubtful change through pre-natal influences received through the mother; the whole reduced by untoward influences, many or few arising from transmission or failure in early nutrition, and to be modified in every part by the fact that he is a man."

"But these fractions indicate only potentialities. These make up the architect's plan on which the man is to be built. The plan admits of much room for deviation. Every wind that blows will change it a little. These elements themselves are of varied character. They do not belong together nor are they held in place, so far as we know, by any 'ego' except that made by the cell alliance on which they depend. Some of these elements, the experiences of life will tend to reduce or destroy. Some of them will be systematically fostered or checked by those who determine the man's early environment. The final details will be beyond prediction. The ego or self in the life of the man is the sum of his inheritance, bound together by the resultant of the consequences of the thoughts and deeds, which have been performed by him and by others also. Thus each day in his life goes to form a link in the chain which binds his conscious processes together. The 'vanished yesterdays' are the tyrants of to-morrow. The higher heredity is the heredity from ourselves."

Dr. Woods Hutchinson has cleverly summed up the Weismann theory in the following words: "Complex and wondrous conceited as we are, we are little but carriers of the germ-plasms,

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lanterns to protect from the gust of circumstances the torch of the life of the race within us. Almost the only way we can possibly affect the next generation is either to starve or to poison, by the toxin of infectious disease or by the external poisons like alcohol or lead, the blood which nourishes the germ-cells within our bodies."

Race improvement must rest on "selection" good or bad. In other words, a wise process of selection will determine the future welfare of the race. What are some of the fundamental factors in that selection or as it may be called "artificial selection" that would work practically for this desired result? Obviously, as far as possible, because of their direct or remote influences environmental conditions should be made wholesome, and reference to this will be made following some suggestions on improving the mating conditions of that large and educatable class known as normal recessives—meaning of course, persons who are themselves normal but having in their bodies the certainty of transmitting certain diseases or the tendency to these diseases, to their offspring in the first or succeeding generations.

Preliminary to some suggestions as to the mating of recessives with taints tending towards insanity and the psychoneurotic states it is necessary to note that there are six combinations of mates with reference to insanity that give rise to the theoretical expectation of different kinds of offspring, as follows (according to Dr. A. J. Rosanoff):

(1) Both parents being insane all the children will be insane.

(2) One parent being normal but with an inherited insane taint from his ancestors, and the other parent being frankly insane, half the children will be normal and the other half will be insane; but even the normal children from such a mating will carry the taint of insanity in their germ-plasm and will be capable of transmitting it to subsequent generations.

(3) One parent being normal and of pure normal ancestry and the other parent being insane, all the children will be normal but will all carry the insane taint in their germ-plasm.

(4) Both parents being normal but each with the insane taint from the ancestors, one-fourth of the children will be normal and not capable of transmitting insanity to their progeny; one-half will be normal but capable of transmitting the insane make-up; and the remaining one-fourth will be insane.

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(5) Both parents being normal, one of pure normal stock and the other with the insane taint from his ancestors, all the children will be normal, but half of them will carry the taint of insanity in their germ-plasm.

(6) Both parents being normal and of pure normal stock all the children will be normal and entirely free from the taint of insanity.

Theoretical expectations and actual findings, as related to the Mendelian theory, do not, as is to be expected, always show an exact correspondence but are an expression of possible chance. Dr. Rosanoff's tables in his article on "Heredity: In Relation to Insanity and Eugenics" relating to psycho-neuropathic offspring and normal offspring, according to the Mendelian theory, are well worth studying and justify the conclusion, he thinks, that insanity is transmitted from generation to generation according to the Mendelian proportions.

These six possible combinations should always be borne in mind in our efforts to solve the marriage and mating problem of not only those suffering with the frank symptoms of inherited insanity but those normal recessives whose sane and high sentiments make them more difficult to deal with in this regard.

Sensational or drastic methods of legislation are not here proposed to prevent normal recessives from marrying or mating, but to educate and regulate them, as suggested later. The slogan to bring about a change of public sentiment as to the danger of unsuitable matings must be, "educate, educate." We should have, by every possible means of publicity and education, the main truths brought out with regard to insanity, promulgated by physicians, by public speakers and lecturers, by ministers of the Gospel, by the school books on sexual hygiene and physiology, by means of popular articles in the lay and scientific publications and by every other possible means.

Such a wide-spread campaign of education of the people as to the truths of heredity and eugenics and as to the means of race improvement, should be accompanied by plain warnings as to the danger of unfit matings and at the same time confidential, free medical advice to the poor should be provided by law, so that those interested would be stimulated and encouraged to discuss this

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question as widely as possible and to seek counsel and advice from physicians and others competent to counsel and advise them.

We have only to recall case after case in our own experiences and to look up some of the thousands of charts that are accessible, showing the lamentable consequences of such unsuitable matings, to be impressed that even the limited elimination of insanity and many other hereditary diseases by the education of this large class of normal recessives in this direction, would prove on our part and on the part of the nation, worthy of our best efforts and any expense. In working out the problem we must also have in mind how neuropathic and other tainted stock is developed by bad mating out of an original healthy stock and how even epilepsy, insanity and neuropathic and psychopathic states have been thus developed through a number of generations, notwithstanding nature is always trying " to end or mend " by " natural selection," sexual selection—aided by anticipation—a stock that has become degenerate. As illustrating the elimination of even epilepsy running through several generations of tainted stock, by suitable matings of the normal recessives of that stock, and also as illustrating the development of epilepsy, insanity, neuropathic and psychopathic states in previously healthy stock by matings with tainted stock, the hereditary charts and family histories prepared by F. W. Mott, an eminent English authority, are illuminating and suggestive along the lines of the object of my paper, which is to present some practical, unsensational suggestions that, if followed, would materially lessen the preventible race impairment that is now surely going on.

If we consider not only the economic loss amounting annually to hundreds of millions of dollars caused largely by inherited diseases, as represented in the dependent classes in the United States, according to the last United States census (approximately over 125,000 insane; over 100,000 feeble-minded; 100,000 deaf and dumb; 100,000 blind; 100,000 in prisons; 150,000 in reformatories and industrial institutions; 75,000 paupers and in almshouses; 500,000 defective in intellect, hearing, and vision; over 100,000 sick, deformed and crippled; approximately 2,000,000 in hospitals, homes, etc., or a total of approximately nearly 3,000,000 dependents, in all these classes); but also the loss to the race caused by the death of one-half million children yearly in the United States and

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the further enormous economic and racial loss caused by the fact that approximately 30,000 to 40,000 of the children who survive annually are born through such bad hereditary conditions and with such serious physical or mental defects that they are a burden to themselves and to society, which is more and more contaminated by them, we as physicians, humanitarians and economists realize the importance of doing our part to help in the solution of this difficult problem.

Can we define ours as a truly enlightened, highly civilized and efficient nation, in which one person in about every 33 must be classed as inefficient, defective, or dependent?

In the words of Kellicott "the time is arriving (and I will add that in fact it has arrived) when we must begin to think of the future of our communities and nations and of our race, rather than to contentedly read of and meditate upon the great achievements of our past, or to parade with self-satisfied air through the glass houses of Anglo-Saxon supremacy. Even were we un-threatened (and I would add that we are now actually threatened) were we amply holding our own, the mere fact of the possibility of a natural increase of human capacity would make it a practical subject of the utmost importance. We may be sure that somewhere a nation will avail itself of such a possibility as the increase of inherent, native, latent, physical, mental and moral inheritance, and will tend to become strong and dominant people. Why should we not be that people?"

Appreciating the well-accepted idea of the influence of environment and training, how shall we nurture, protect and develop the approximate one-tenth of the human species who are to become the parents of the coming race, by environmental influences?

If the United States government can, by wisely expending, as it does, hundreds of thousands of dollars annually to eliminate diseases of cattle, of swine and the spirochete disease in the horse (comparable to syphilis in the human race) why could it not with more humanitarism and wisdom, spend an equal or greater amount for the same and similar purposes to benefit human beings, whose physical, mental and moral health must in the end be either the glory or downfall of the republic? Parenthood with the race is everything that makes for either progress or impairment and probably the more important element in parenthood is motherhood.

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Are the federal and state health agencies doing their full duty to eliminate disease, particularly those diseases which by impairing the health of the mother during and before the child-carrying period, naturally impairs the health of the fœtus, and the adult growing from the fœtus? Surely our economic and sociologic good sense should teach us that the first essential in well-ordered society is to see that the slums, sweatshops, bad factory and industrial conditions, poisoned foods, poisoned moral surroundings, vicious environment and all that militates against the physical, mental and moral health of the masses of the people, especially the pregnant and nursing women, as well as the children and younger people, should be intelligently and rigorously stamped out. It is inconceivable that there should be in this great republic, in this day and generation, such an economic condition as would allow the mothers of the future race to dwell in squalor, filth and generally bad and unhygienic surroundings and without sufficient food.

No generation, either of man or animals or plants, determines or provides the future of the race, as a small percentage, as a rule of any species reach maturity and *only about one-tenth of those give birth to the next generation.* The world may owe much to some of its geniuses whose extraordinary mental abilities may have been, as pointed out by Lombrosa, the expression of epileptic equivalents, or the "degeneration of genius," without the force of which we may not have had the influences of some of our greatest reformers, like Mohammed, Joan of Arc, and others. These, as Saleeby says, in the long run, make history. "That a Kant or a Spencer dying childless may leave what we call immortal works, but unless they and their class become parents or unless the average parents of *each* generation are rightly chosen or selected, a new and inferior generation will arise, to whom the greatest achievements of past generations are as nothing—'as pearls before swine.'"

The self-evident fact presents itself that the character of a nation, even one so great as ours, is necessarily the character of the people, the average people, *i. e.*, the individuals who make up the nation. Character is greatly determined, as we have seen, by heredity. Improvement of heredity is naturally very slow and is a matter of averages, this also being true of race decadence.

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Some of the great laws—the "Law of Averages" and the "Laws of Evolution"—to which reference has been made, have enabled us to preserve what sanity and stability we have. But for the workings of these laws, we would probably be overrun by the monkey geniuses and the mattoids of Lombrosa and other degenerates, as well as thousands of over-educated, over-cultured, inspired idiots and fools of all ages, all or most of whom are capable of propagating their species. Another law applicable, is that nature seems to strive for mediocrity; as a seeming contradiction to this law there frequently arises from the happy mating of so-called common or mediocre folk some splendid men, like the illustrious Abraham Lincoln and many others of the world's notables, who sprang from average, rugged, hard-headed ancestors, who, like Lincoln's immediate ancestors, had a good lineage generations back and an immediate ancestry that was hardy and healthy in the sense that their transmitted characteristics were convergent or cumulative in the person of Lincoln. The same may be said of the famous John and John Quincy Adams, father and son! It is interesting to note in this connection on the authority of Reibmayr, that genius does not carry down the stock and that on the contrary, it is a remarkable fact that the male line, where there are children rarely extends beyond the third generation (see a list and table of the world's geniuses by Reibmayr). A striking comparison is here suggested between the Adams family of Massachusetts and the notorious Jukes family. The ancestor of the Jukes family, born in Orange County, New York, lived (grossly immoral sexually and otherwise) to a great age and became blind, leaving numerous progeny, many illegitimate. The number of individuals of this family, through several generations, aggregated about 1200, including mostly criminals, prostitutes, vagabonds and paupers, and only a small proportion of honest workers.

The sociological side of eugenics was, as far as we know, first emphasized during early Greek civilization. As expressing this Plato stated clearly the essential idea of inheritance of individual qualities and the danger to the state of a large and increasing number of degenerates and defectives, called upon the legislators and sociologists to purify the state with the result that exists in our

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own day, namely; that the able-bodied and able-minded continued to be sacrificed to the god of war, while the less fit, the weak, the degenerates and defectives were left at home to become the fathers of future generations. Greece is to-day, and has been for many decades past, a most conspicuous warning of such a policy.

The eugenics of the gigantic world war, involving, as it does, most of the great races of men, is racially, economically and sociologically one of the large questions of the war, or rather of its dreadful consequences. With the flower of the manhood of the many belligerent nations engaged in destructive fighting at the front, the normal birth-rate in even so fruitful a country as Germany has sharply declined since the first year of the war at least 30 per cent.

This is true both because of the absence of so many fruitful younger men and because of the impaired physical condition of the men and women who remain at home, resulting from the stress of war.

It was observed in France, commencing with the first generation after the conclusion of the Franco-German War, that the average height of the men was two or more inches less than previous to the war—and this same effect (and other effects of physical stunting) of other great wars have been noted.

It is easy to see the effects on children begotten under the conditions named and under conditions of lowered vitality of the older men who stay at home. Fortunately the law of the *continuity of the germ plasm* applies in the cases of the thousands of armless and legless soldiers, so that their children will not inherit such conditions.

Let us call attention in this connection to the fact that there are born from the world's present population of approximately one and a half billion people, about fifty million children each year, and from a population of about one hundred million in the United States, about two and a half million children yearly; one-half million of the latter die during infancy, and one-half of the remainder die before reaching their twenty-third year. It is safe to say that from 3 to 4 per cent of all these children who survive are physically or mentally defective, to such a degree as to be a burden to themselves and to others. All these and many other

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appalling racial and social conditions from the sociologic viewpoint, are strictly in accordance with the operation of the laws of "natural selection" unchecked and working blindly. It is this unchecked and blind working of the laws of "natural selection," in certain directions, that it is suggested to remedy by what might be called "artificial selection," with the concrete purpose of eliminating as many human weaknesses, diseases and defects as possible.

Aside from vicious environmental conditions, we know that tainted heredity from all causes is responsible for the direct inheritance of and the diathesis to such mental and neuropathic diseases as the manic-depressive psychoses, dementia præcox, epilepsy, imbecility, idiocy, feeble-mindedness, Huntington's chorea, Friedriech's disease (hereditary ataxia), Thompson's disease, familial tremors, muscular atrophies and dystrophies, multiple sclerosis, cerebral hemorrhage, arteriosclerosis and senility, the neuropathic constitution, etc., as well as the diathesis to tuberculosis, diseases of the respiratory mucuous membranes, syphilitic taints, heart diseases, eye defects, rheumatism, kidney diseases, skin diseases, etc., as well as cases of alcoholism that are apparently inherited and which must be included in this large class of inherited mental diseases, as must also a certain class of explosive persons who find it impossible to control their impulses and animal instincts.

Some able investigators and thinkers along these lines have concluded that while race impairment is appalling and preventable, the time has not yet arrived, in their opinion, to take genuine, practical steps to remedy the evil. The day and time in which we live is characterized by the stern disposition to meet emergencies and social evils, as never before, and while I do not advocate too drastic or unconstitutional methods and laws to control the propagation of even the grossly unfit, such as confirmed habitual criminals, rapists, certain defectives, degenerates and feeble-minded, I am of the opinion that the worst of these classes, who cannot be effectively and constantly segregated, should come within the laws enacted by the states of California, Indiana, Connecticut and other states, requiring the sterilization of both men and women of these classes, under conditions that safeguard their personal and constitutional rights. That these laws, drastic as they may seem, are not considered inhuman or cruel by those to whom they apply, is evidenced

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by the fact that individuals not coming strictly within the provisions of these laws, have, as is recorded in the state of Iowa, requested that they be sterilized by the operation in the male of vasectomy or, in the case of the female, by the removal and tying off of a portion of the Fallopian tubes. One of the most urgent reforms in the direction of segregation, are better regulations by the Local and State Board of Health for following up those suffering with chronic alcoholism and also that large class, primary secondary, and some of the tertiary, stages of syphilis and other communicable venereal diseases; in the case of the syphilitic the observation and regulation should extend for at least a period of five years, after which period, they may, in some cases, according to certain authorities, beget healthy children. This suggests every possible extension of the work of the American Association for Education in Sex Hygiene.

Recent laws enacted in the states of New York, Minnesota, and other states of the Union, designed to promote eugenic marriages, require that applicants for marriage licenses shall make a sworn affidavit that they are not suffering with communicable venereal diseases. While these laws may not deter the most thoughtless and vicious they will undoubtedly prove beneficial by punishing violators, in certain cases, for perjury, and will thus also become educational.

These and other laws and marriage regulations, like those suggested by Dr. Adolf Meyer in his valuable contribution to eugenics and heredity, "The Right to Marry," in which he advocates the publishing in this country, for three weeks, of the marriage banns, as is widely done in most European countries, will in the end have a salutary effect, both by preventing some ill-considered matings and in a larger degree, by calling public attention to this whole subject.

I would suggest that, supplementing the marriage laws and regulations already in force in some of the states, that there be enacted in every state of the Union a uniform law providing for an impartial board of competent, high-minded physicians and sociologists to be appointed, as free from political considerations as possible, by the governor of each state, which board shall act upon every application for marriage licenses, with the power, if in their opinion it is necessary, to make a thorough physical

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and mental examination of every applicant for a marriage license—the members of this official board not in any case to receive money or compensation from the applicants themselves, but to be paid a fixed salary by the state, the same fee whether they accept or reject applicants for licenses. In addition to these duties such a board should have broader duties. To deal wisely and humanely with the grossly unfit as well as with that large class of normal recessives would prove a difficult task for the board I have proposed. And to deal with even measurable success with normal recessives (in so many cases a useful and helpful factor in society) would help to solve one of the greatest sociological, economical and humanitarian problems of this and possibly of all ages.

Here there is the widest field for the exercise of humanitarianism, good sense and profound sociological and scientific medical training. The official acts of the proposed board in the cases of most normal recessives should of course be in an advisory capacity to those who apply for guidance and advice with regard to mating. Tactful procedure and proper educational methods would doubtless, in a few generations, bring to them and to society at large astonishing results.

It is obvious that the membership of the board should be made up of several of the larger elements of society at large, namely, a physician, practically trained in insanity and hereditary diseases, eugenics, criminology and sociology; two or more members who should represent the dormant religious organizations of the respective states; one to represent the best labor organizations and one to represent the agricultural interests in the farming states; also a layman who should be a broad-minded student of sociology in its modern sense and a legal member to safeguard the board in proceeding according to the strict forms of law and the constitutions of the respective states and of the United States, guaranteeing the protection of personal liberties of those to be passed upon by the board. The board should carefully study and pass upon, as a whole board, the case of each person whose case shall, under statute, come before the board, for vasectomy, ovariotomy or segregation as grossly unfit to beget children.

The membership of the board should be made up of the best men and women, conscientious, well-trained and fearless and it

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should be selected and continued in office regardless of political considerations. The details and machinery for the creation and workings of such a proposed board could be made an extension of the present powers of the existing Boards of Health, local and state.

Environmental factors which it is within the province of the state and nation to control or modify, as well as the educational and religious training and all the surroundings that our civilization has brought, both good and bad, must, to a greater or less degree according to the consensus of opinion on this subject, influence heredity, as is shown in the familiar cases where vicious environment has caused alcoholism; and alcoholism in its turn has caused, in successive generations disease, pauperism, epilepsy, insanity and crime. Again the importance of good environmental conditions is emphasized by the fact that the thousands of weaklings resulting from inherited toxic poison, syphilis, etc. (and even the fœtus influenced in utero by these poisons, after the birth of the child and its removal from the tissues and fluids of the diseased mother), tend under wholesome environment to immediately rebound in an effort to gain normal character. The same may be said of children born of tuberculous or anæmic and otherwise enfeebled mothers and fathers.

Since the individual is only the product of what is in his father and mother, plus the individual's environment, mating is a matter of vital importance and it is in this matter that we as physicians can, by employing the laws of eugenics, be of the greatest service to posterity and to those who are wise enough to consult us regarding proper mating. By encouraging this practice the physician can, more than any other social agent, help to eliminate the inheritance of mental diseases and of bad traits and tendencies.

In spite of our best efforts in the direction of better mating, we shall for a long time have defectives in our midst. Believing that many a just cause, scientific as well as moral, has been injured by wild, impractical claims of too enthusiastic but well-meaning reformers, who would in a moment reform everything in the world except themselves, I do not wish to be construed as approaching this subject in the spirit of claiming that eugenics has advanced as rapidly as some other sciences, or that it or any of the other of the many sciences have as yet been perfected into exact sciences,

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or that the beneficial principles of eugenics will or can be so rapidly carried out as to produce in a few decades a perfect race of supermen or super-women, or physical or mental giants, but I do insist that if its great underlying laws are sufficiently understood and seriously considered, that fair-minded men and women will admit that the present investigations and known truths regarding eugenics justify the full acceptance of certain generalities on this subject, which if properly applied would lead to the immense improvement of the race by better breeding and the elimination of a vast number of preventable mental and other diseases.

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THE TOXIC PSYCHOSES.

By G. W. BROWN, M. D., Williamsburg, Va.

The toxic psychoses are generally understood to refer to the deliria of the acute infectious diseases, such as those occurring in influenza, typhoid fever, pneumonia, etc., but there are a number of psychoses that bear a close relationship to the toxic psychoses. This relationship is probably coincidental instead of causal, and it is true that a large percentage of this class are psychopathic inferiors, but the constant poison of chronic physical disease acts as a contributing cause.

The somatic diseases most commonly seen on admission to the hospital are: Syphilis, tuberculosis, nephritis, cardiovascular disease, diabetes, carcinoma, etc.

In the past six months we have had a Wassermann done on every patient in the hospital and we have found that several of the old patients who have been at the hospital for more than 25 years, suffering with circular insanity, having repeated maniacal outbreaks, violent, destructive and filthy, gave a 4+ Wassermann. One of these patients, an inmate of the hospital for 34 years, was given repeated doses of diarsenol and since the treatment he has made marked improvement, is more rational, cleanly, and has passed his usual period for his maniacal attack. Sufficient time has not elapsed for us to have a definite opinion as to whether or not this improvement will be permanent. Another patient, a female, married, and having two healthy children, but giving a 4+ Wassermann, showed symptoms of catatonia and again of a mixed mania; she was untidy, destructive and violent. This patient was so resistive that a careful neurological examination could not be made. She was given diarsenol and after the first intravenous injection of 0.4 gram had a severe reaction. The dose was repeated on the eighth day and again a severe reaction occurred. About a week after the second dose she began to work about the ward and is more amenable to discipline. Up to the present time she has only received four doses, but continues to improve.

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I will cite three cases, each diagnosed as dementia præcox, of a more recent admission who also gave 4+ Wassermann's. One of these cases was undoubtedly a præcox who, after the fifth dose of diarsenol, had recovered sufficiently to be granted a parole. The other, No. 2874, was a male patient, 24 years of age, and a clerk. His commitment paper stated that the attack began in December, 1913, at which time the patient gave up his position on account of imaginary grievances, laziness and loss of ambition. Patient was violent, destructive, untidy and homicidal. The family history states that the father is an alcoholic and his mother died of pernicious anæmia. This patient was in a private institution for nine months previous to his admission. The physical examination revealed the fact that the patient was very anæmic, fingers clubbed at the ends, would sit in a rigid position, was somewhat resistive, assumed peculiar attitudes, was oriented as to place, but not to person and time. He gave no neurological symptoms of syphilis, but gave a 4 + Wassermann. Diarsenol was given this man, and after the second dose he began to improve, took notice of his surroundings, became tidy and began to do some work. After the fifth dose he had improved sufficiently to be sent to the farm. We feel that in a few weeks this patient will recover.

Still another case similar to the one just described is that of a young man only 18 years of age, but this patient had loss of patella reflex.

A large number of patients with chronic nephritis, especially of the interstitial type, reach the state hospitals undiagnosed, and again we found in several psychoses and some of the undifferentiated depressions either old tubercular lesions or else mildly active ones.

I recall two cases of cancer that were improperly diagnosed and committed as insane. One of these cases, No. 2581, was a female, 62 years of age, admitted May 16 and died May 24. This patient was mildly delirious instead of insane. She was oriented and answered questions intelligently. She stated that she had been suffering pain in the abdomen for several months. She consulted a surgeon who advised her commitment to this hospital. Upon examination we found a mass in the left hypogastric region and tenderness over the liver. At times she was delirious and moaned with pain even when asleep. Another surgeon had advised against

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surgical procedure. Autopsy showed carcinoma of the sigmoid and a small carcinomatous nodule on the liver.

After influenza, especially in people past middle life, we find marked dementia. When the patients regain their physical tone after a period that varies from a few weeks to a few months they regain their mental health.

About one year ago we had a female patient, aged 48 years, who had been committed with the diagnosis of acute mania. This patient was found to be suffering with diabetes. In a few weeks she had sufficiently recovered to be permitted to return to her home. She and her husband were told of her grave physical condition and were advised in reference to same. A period of six months elapsed and the patient was returned to us in a state of diabetic coma and died after four days.

Some of the most distressing cases of the toxic type we find in cardiovascular diseases. These patients improve for a time, but frequently relapse and are extremely trying until the stage of complete dementia is reached.

Organic heart disease, especially aortic insufficiency, causes depression which frequently has a suicidal tendency. After a few weeks' rest in bed these patients recover and remain well until overwork again causes decompensation, when the mental symptoms return.

It can be stated without fear of contradiction that a large number of patients who reach mental hospitals would not develop psychoses if their somatic diseases were diagnosed in their incipiency and the proper treatment administered. A great deal is written about the prevention of insanity and various impracticable ideas advanced, but little is said about the early diagnoses with proper treatment of physical disease.

In all hospitals it is an accepted dictum that all admissions should have an immediate preliminary mental examination and a sufficiently thorough physical examination to detect acute diseases, injuries, and gross lesions of the heart, blood vessels and kidneys. I am firmly convinced that the future welfare of the patient demands a searching physical examination as promptly as it can be made. A few days will make little difference to the patient whether his case is diagnosed manic-depressive or allied to manic-depressive, but he might lose his life if we failed to

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diagnose a myocarditis in the stage when treatment held out hope of benefit. Even if we could not cure them we could aid their waning strength and permit them to end their days in their own homes surrounded by their loved ones. It is almost criminal to commit an old person, suffering from the toxic effect of chronic cardiovascular disease or nephritis, to a state hospital, when a few warm baths, a dose or two of calomel, and proper diet would tide him over the attack and he would go for weeks in comparative comfort. Hospitals for the insane are necessities, but it would seem that they are being overworked.

For a number of years I did private practice and was surprised when taking up work in a state hospital to find a large class of patients being admitted whom I had been accustomed to treat in their own homes. I began to investigate the cause and came to the conclusion that the trouble was largely due to carelessness in diagnosing physical disease, and I am convinced that more study should be made of the toxic psychoses causing mental illness.

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THE BRAIN

By DR. J. T. SEARCY, Tuscaloosa, Ala.

The brain of man relates altogether to his environment. It is the center of all the activities that bring the person in relationship with what is outside of him. Like all nerve centers, however simple or complex, the brain has afferent and efferent nerve lines coming to it and going from it. The first object of brain effort on the part of all living things, man included, is to continue themselves living. The immense complexity of cells and fibers of the brain in man has been built up, within the skull, by the psychic efforts of ancestral individuals and their posterity, continued through countless generations, in keeping themselves living in the adverse circumstances that surround them. Countless lines have been eliminated, those living to-day survive by their improved cerebral capabilities.

Brain improving effort alone has been in man the reason for the immense size and the immense complexity of structures of his brain, with its exceeding efficiency of functions. It has been built up into two connected, conscious, convoluted hemispheres and is the center of the afferent and efferent nerve lines coming from the sense organs and going to the voluntary muscles on the two sides of the body.

By improving effort and practice, through the ages, man's brain transcends in qualifications the brains of every other species; with its excellence, he has been enabled to better provide for himslf, and multiply himself more numerously in the world; until now he occupies all its habitable portions, and claims all for himself. With it he has eliminated all other serious competitors, until his only rivals now are his fellow men. The competitive life, that has existed among men for generations on generations, has been mostly brain-work, which has done more than anything else to still further carry the proficiency of human brain excellence to the supremacy of its present level.

Man has still, however, to exercise and exert his brain with repeated effort, in order to maintain its excellence in society or to

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improve it; so as to continue his existence among the more and more strenuous competitions of his fellow men. Practically all the competitions of human society are brain-work; and the more excellent the brain-work, the more advanced and successful the individual, the family or the race is comparatively shown to be. The competitions among men are, in the large majority, to obtain from the environment the necessaries of life—the hardest of which to obtain is food. A great amount of providing head-work is required, and there is great business rivalry in the competitions with others for the necessaries. "To make a living" requires constant head-work.

Psychology is the study of the normal structures and functions of the brain; psychopathy is the study of its abnormal structures and functions; psychiatry is the care and treatment of its abnormal conditions; a psychosis is an external exhibition of an abnormal brain condition; insanity is such an extreme grade of a psychosis that it brings the person within the cognizance and jurisdiction of a court; sanity is the sum of all the external exhibitions which come from a person's brain, shown in his deportment and in the grade of his social success, which prove that he has a normal brain in his head. We usually estimate his sanity by the grade of his exhibited intelligence and the grade of his moral sense.

There is no constant level of brain abilities in the individual or in his posterity. The extreme complexity of the organ and the delicacy of its structures occasion its ready instability. Its integrity of structures and its capacity of functions are built up and maintained by the activity of its cells in conscious adjustment to the environment; its stability depends upon the strength thus obtained.

Being the organ that relates to the outside, its external exhibitions of abilities and of habits of action are open to the outside observation and criticism of others, who generally judge these qualifications in the two particulars of intelligence and of moral habits. Even men with normal brains differ in their grades of intelligence and of moral habits; hence the necessity of judging all we meet. In the associations and competitions of society it is very important to know these qualifications in others.

The brain receives information, learns in its posterior structures, into which the afferent nerve lines from the several sense

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organs enter—all carrying information of and from the environment into these conscious structures. All the experiences of the person in his environment and all the knowledge he has obtained from his environment are acquired in the posterior portion of his brain. They are all previous brain acts. The brain has the ability to perform again its previous acts in recollecting them. The ability to do this is the faculty of memory. The amount or number of previous acts it can reperform or recollect, in the aggregate, constitute its knowledge.

The anterior tracts and structures of the brain emit its resultant acts or execute them through the voluntary muscles—also capable of recollection. All brain acts can be recollected. Those most decided can be reperformed or recalled best.

Between the posterior receiving tracts of the brain and the anterior executive ones is the whole sphere of conscious convolutions; as complex in organization as its work is complex; engaged in combining its knowledge into conclusions and purposes for execution by the processes that we call ideation and reason. The grade of the man's "common sense" or "good judgment" depends upon the efficiency of these middle tracts of the brain.

There have been formulated in human society an immense line of rules-of-conduct, which are prescribed and with more or less discipline enforced. Man is not allowed to question or disobey them. These rules are the results in society of the associated altruistic reasoning of the ages; and, living in such influences, through the ages, for the good of society, the individual has become habituated to such observances, and grown "conscientious" in their performance. All men hereditarily have such habits, but differ in the grade of their consciences in observing them. Moral habits belong to brains in different degrees of excellence. Law, government, religion, public opinion, moral sentiment in the community, commendation and denunciation, preaching, teaching, polite society and ethical social life, surround the individual and enforce his brain practice and observance of rules of decency, propriety and rectitude. He cannot avoid or escape these controlling agencies. He is criticized and disciplined until such habits of thought become more or less constant with him—ingrained through generations. According to their ancestral and their personal environments, men acquire habits of moral thought

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and action. In judging others, therefore, we judge them according to the grade of their exhibited moral habits, as well as according to the grade of their exhibited intelligences.

In their immense complexity and variability, we look for normal differences in the external exhibitions that come from different men's brains. There are no two alike. They naturally differ in their grades of intelligence and moral habits. Some are naturally more excellent than others; still all are classed natural or normal. When, however, there appears a difference that is not natural, usual, customary or expected, we regard that man's brain as abnormal.

A psychosis, as I have said, is an external exhibition of a brain's abnormality. There are all grades and kinds of psychoses. A person exhibiting a milder grade can still go at large in society, but when his psychosis is so grave that it makes him offensive, troublesome or dangerous to others, it brings him within the jurisdiction of a court and he is declared "insane" and deprived of his liberties—not fit to go at large. All the patients of our insane hospitals have reached such grades of brain deficiency or defectiveness that a court has intervened and declared that they, for their own or public welfare, need the restraint and the care of an institution for the insane. A court alone can pronounce a man insane . . . . defective to that degree. Milder grades of psychoses, however, not segregated into insane institutions, or who do not come before courts for any such purpose, are numerous in society, and are evidently growing more numerous—all grades of simply subnormal brains appear.

Children in the schools appear in increasing numbers, not able intellectually to keep up in their classes; and more are found to be incorrigible to training and to discipline in rules of conduct. The industrial institutions, the reformatories and correctional schools for such children are filled rapidly. The schools for the feeble-minded, homes for old dotards, reformatories for inebriates and colonies for epileptics have increasing populations. These institutions, however, do not relieve, apparently, the insane hospitals of being crowded with the extreme grades. They are calling for larger accommodations. Brain deficiencies and defects appear to increase more rapidly than the population. Penal institutions also are growing more and more crowded.

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Recognition throughout society of these facts is occasioning the forming of numerous sociologic societies and organizations, which have for their object principally the care and improvement of such subnormal and abnormal derelicts and defectives as appear in society, outside of the insane hospitals. But removal of the original brain defects in these deficients is rarely accomplished. We can only polish the exterior. It is discouraging to try to remove the bias of hereditary disabilities and habits.

Such sociologic work, however, is almost universally in the hands of sentimental and sympathetic social workers, who are doing much for humanity, but they do not recognize the brain as the organ or part of the person deficient or defective. It is time a scientific and a practical construction and control should be placed on such work, which will show the physiologic and pathologic naturalness of all such phenomena. Human psychic excellence and human psychic deficiency come from physiologic and pathologic brain conditions that arise and continue in accordance with natural principles and processes. There is no mystery attached to them.

As psychiatrists we generally confine ourselves simply to the care and treatment of the social derelicts that have been placed in our hands by the courts. We work altogether at the foot of the precipice and do not take the field of preventive medicine to stem or divert the drifts and currents in society that carry those who fall, in increasing numbers, over the cliff. We are too reticent and reluctant in entering the field of scientific instruction and preventive control in society, in these matters.

An equal valuation is generally placed upon all human lives alike, and we, under this principle, in the medical profession particularly increase the inefficient in society by bringing up many more of them by our care and treatment to adult life. Deficients and defectives are helped in every way to reach adult life, where they multiply themselves. "Race-hygiene," through generations, is not taught as positively as it ought to be. Brain heredity in posterity and brain hygiene in the individual are sadly needed subjects for public instruction by scientifically qualified physicians. The field ought not to be left altogether to the sympathetic and sentimental social lay workers, who usually study such subjects from an extra-somatic and metaphysical standpoint. "The study

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of psychology is a natural science and not a minor branch of metaphysics."

The brain in its grade of qualifications is as much a matter of heredity as any other organ in the body; probably more so, because it is more recently evolved and more readily varied and changed. It is true, mental heredity and eugenics are becoming subjects to some extent popular in sociology. The practical necessity for it is being gradually recognized. Still, because not scientifically understood, human brain heredity goes at loose ends. To improve man's brain hereditarily by the proper selection of parents is not taught or observed as much as it ought to be. Race improvement, with reference to better brains in posterity, is not recognized sufficiently. This is a field for much needed instruction. Man's specialty, of brain abilities, can be as much improved hereditarily as the specialty of any one of his domestic animals by the proper selection of parents. Heredity in the painted white-house on the hill is the same as that in the barnyard and the pasture. It is neglected almost altogether, while every care and attention is bestowed on the other. Reform in this matter is a difficult question to handle; little or no reference to posterity is made, as a rule, in the mating of men and women. Sex appetite prevails, and is the almost universal reason for the matings, and more than anything else leads to the multiplication of the less and least competent. The less competent multiply most, only following sex appetite.

The subject of brain hygiene in the individual is also much neglected. It is true a great deal is done to improve brain ability in the individual by the brain practice required in education, and by the continued brain-work necessary in order to survive in adult life, in the competitions of society; so, in this way, we do unintentionally improve brain abilities, without any particular rule or reference to the brain, however. The success of a society or of a race depends upon the amount and kind of brain-work going on in it. This is not done, however, with any reference to brain physiology. Deterioration by brain idleness or brain abuse is not taught. "Mental" functions are usually considered constant. All men are held equally valuable and responsible; without consideration given for inherent differences in human brain abilities and their variability.

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The prevention, too, of direct injury to the sentient structures of the brain by the chemic action of narcotic drugs, such as caffein, nicotine, alcohol and some stronger ones, like cocaine and morphine, taken as luxuries in society, is being popularly very indistinctly recognized, because practical scientific interpretation of the injurious practices, as belonging particularly to the brain, is not as generally taught by the medical profession as it ought to be. A " habit " from the use of any of these drugs simply means that sentient and conscious structures of the central nervous system, the most tender and delicate in the body, have been rendered more sensitive by the repeated chemic action of these agents, until the person feels generally discomforted unless dulled by their continued use. There is always a continued increasing condition of discomfort, unless relieved by more of the drug. Social brain hygiene, nowadays, ought to be greatly concerned along this line.

Social or race hygiene, through proper brain heredity, and race hygiene, by averting brain injury from the popular use of many damaging toxins, are both vital sociologic questions, for which medical men are principally responsible.

Of course, brain injury from autointoxication by toxins that arise within the body, most frequently from the digestive tube; and injury, that comes from the strain and stress of repeated cerebral convulsions, in epilepsy; and the damaging injury in the most delicate structures of the brain, by the spirochetes of syphilis; with injuries by many other agents; are topics for the study of brain hygiene by medical men. Psychiatry has an immense field to occupy.

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THE VALUE OF OUT-PATIENT WORK AMONG THE INSANE.

By A. WARREN STEARNS, M. D.,

Assistant Professor of Neurology Tufts Medical School and Assistant Physician Psychopathic Hospital, Out-Patient Department, Boston, Mass.

One of the most important developments in the caring for patients with nervous and mental diseases has been the extension of out-patient work by state hospitals. This work is new enough so that it seems worth while for those engaged in it to compare notes frequently. This paper aims to describe and to discuss briefly the work of the Out-Patient Department in the Boston Psychopathic Hospital, this department now being in its fifth year, and so one of the oldest.

The clinic is held daily from 2 to 4 p. m., and Wednesday evenings.

There are three departments, namely:

1. Medical.
2. Social.
3. Psychological.

The medical department is made up of a part-time or visiting staff, who do only out-patient work, assisted by internes assigned from the house staff.

The social-service and psychological departments do both house and out-patient work and are not exclusively attached to the out-patient department.

Upon coming to the hospital, the patient is met by a clinic manager, who takes the history, and directs the patient to the different departments. Much time is saved by supplying social agencies with a blank history form so that most of their patients come with a complete typewritten history. These patients can then be referred directly for physical examination, and if the problem is one of defect, to the psychologist, reaching the doctor when completely examined. If the problem is not one of defect or is doubtful, the

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patient is referred to the doctor after the history has been taken and all physical examination made. A Wassermann blood test is made on every patient. As the clinical manager is attached to the social-service department, she has in mind the social needs of each case, and can call the attention of the social-service department to such need, but most patients are referred to the social-service department by the doctor after his interview. If diagnosis is impossible and more observation necessary, or if the patient has a psychosis, he is now referred for admission to the house.

During the last hospital year, October 1, 1915, to October 1, 1916, 1485 new patients were received at the department, and 9261 total visits were made.

The sources from which these new patients came were as follows:

Psychopathic hospital (after care)	413	
Charitable organizations	402	
Other hospitals	193	
Own initiative	167	
Doctors	104	
Courts	97	
Schools	69	
Miscellaneous	40	
		1485

The following diagnoses were made:

Feeble-minded	298	
Sub-normal	21	
Retarded	68	
		387
Alcoholic psychosis	47	
Dementia præcox	72	
General paralysis	24	
Manic-depressive insanity	30	
Senile psychosis	3	
Psychopathic personality	29	
Unclassified and miscellaneous	34	
		239
Alcoholism	43	
Syphilis	73	
Psychoneurosis	149	
Chorea	11	

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Epilepsy	37
Speech defect	55
Drug habitués	5
Constitutional inferiority	5
Delinquency	41
Organic nervous disease	25
No nervous or mental disease	105
Non-syphilitic	131
(These were members of families of syphilitic house patients sent in for blood examination.)	
Deferred and miscellaneous	150
Total	1485

About one-half of the patients are problem children, the figures of January, 1917, illustrating this:

Male adults	22
Female adults	49
Children	65
	136

Although to quite a large extent this is a consultation clinic, and diagnosis is the essential object sought, the following different forms of treatment are used:

Hydrotherapy.—The hospital is equipped with a standard hydrotherapeutic room, to which out-patients are referred, usually being given three treatments a week.

Psychotherapy.—Patients requiring psychotherapeutic treatment are referred to special workers along this line.

Social-Service.—Some patients are referred for more investigation to aid diagnosis, others for employment, a special worker being maintained who has charge of the latter. Many are referred for supervision, it being found that certain tractable insane persons, or those with abnormal personalities, can get along satisfactorily in the community with a varying degree of social-service supervision.

Speech Training.—A special clinic for speech defects is in operation for this class of cases, being held two afternoons a week.

Men's Club.—An informal club, with weekly meetings, has been organized principally to interest and help alcoholic patients, but other types are admitted. The active membership is now 86 men. A women's auxiliary, composed of wives of members, has also

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been organized. This club seeks to furnish a certain amount of entertainment and recreation to keep the patients' association with the hospital, and to encourage members to help each other.

Anti-Syphilitic Treatment.—All patients with a positive Wassermann or evidence of syphilis are referred to special workers who have charge of the syphilis problem.

House Observation.—As stated above, patients needing observation or temporary care are referred directly to the house.

An important aid to efficient work is the follow-up system. At each visit of a patient a slip is sent to a special follow-up worker, giving date of next visit desired. If the patient does not report on that date a formal printed letter is sent as a reminder. If this does not bring the patient the telephone is tried, and if unsuccessful, the patient is visited by this worker.

Of 577 new patients told to return, 312 came without, 48 with, a reminder.

Of 375 house cases referred to the out-patient department, 184 came without, 38 with, a reminder.

Of 6635 total vists, 5852 came without, 783 with, a reminder.

The exact expense of the out-patient department cannot be given at this time, but appears to be between $1.50 and $2.00 a visit. This should be compared with the 18 cents to 57 cents per visit, as given by Mr. Davis in a report of a committee on out-patient service of the American Hospital Association.

For some time the writer has been of the opinion that a great many of the patients admitted to the house for 10 days' observation could be as well handled by the out-patient department, and with this in mind 100 consecutive house admissions were examined and the opinion formed that 35 of these cases could have been cared for as well by the out-patient department without house admission. These are largely cases where diagnosis is the object sought. Obviously an out-patient visit would be much less expensive than 10 days' house observation. From the experience of the past five years, a few points seem of special importance:

1. Inasmuch as the clinic is quite largely for consultation, there must be a well-trained and mature psychiatrist in charge. The large proportion of neurological material commonly forming an out-patient department makes some special training in this branch necessary.

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2. Lack of adequate facilities for caring for psychoneurotics is apparent, it being almost impossible to get free beds for this class of patients.

3. Need of elaborate equipment and many workers to carry on psychiatric out-patient work.

The examination is so complex that unless several persons can be engaged at once, few patients can be examined in an afternoon. This makes it seem wiser to hold out-patient clinics at hospitals where entire staff will be available, rather than in outlying districts. Prejudice of people against going to hospitals does not seem to be a sufficient argument to warrant the waste of effort entailed by sending a staff of a hospital to distant points.

4. The important position of social-service in out-patient work.

Doctors must realize this and give the social worker more recognition, just as a trained nurse or psychologist goes into certain detail better than a doctor, so a trained social worker is fitted to take charge of that branch of our work under medical supervision.

5. Out-patient departments are an advantage: First, to patients, in that many prefer staying at home and are happier and better off there, as are their families; second, to the state, in that home care can save much expense under supervision. With stimulated and instructed family interests, many now a burden to the state may be self-supporting; third, to the doctors themselves, as they see a vast variety of nervous and mental disease not seen at the hospitals and so get a broader training. It also furnishes a place where psychiatry can be kept pure, as doctors and special workers connected with social agencies and courts get a one-sided experience and do not become good psychiatrists. By working part-time in out-patient clinics connected with hospitals, they can keep in touch with the whole field.

DISCUSSION.

DR. BRIGGS.—Mr. President, I should like to say that the out-patient departments as organized in Massachusetts and now in New York, constitute the first organized effort for the prevention of insanity in this country. Out-patient departments have been used in Massachusetts in two hospitals for many years. When the State Board of Insanity asked the State Hospitals of Massachusetts, one and all to establish them, the response was immediate and successful, and to Dr. Stearns should be given the credit of this success in large measure. He visited each hospital, he

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helped in the organization, in the forms used in the different records and in many ways the assistance given by him was responsible for this success of the movement. It was predicted that it was more or less of a fad and that it would soon die out, but instead of that it has grown steadily to very large proportions; and I think that every superintendent who has an out-patient department has felt that he is doing good work in the prevention of insanity. Physicians in the country towns where the clinics are held bring patients for consultation, or attend the clinics and ask the superintendents who have had much experience in the care of the insane, advice concerning their cases. The early patients attend the clinics and the discharged patients report there, obviating the necessity of return to the hospital; and, therefore, I feel that every state should organize out-patient departments as a preventive measure.

DR. OSTRANDER.—Mr. President, I would like to state that New York and Massachusetts are not the only states that are doing work of this kind. There is an out-patient clinic in connection with the Psychopathic Hospital at Ann Arbor, and the Kalamazoo Hospital, of which I have charge, have four out-patient departments, and these are conducted with out any help whatever from the state of Michigan. There is no state provision for financing any such thing. We have gone to county officers and asked permission to start these clinics in their midst and they have paid the expense, and I am not sure but that is the best way. The plan is no longer experimental, we no longer have to ask the counties to let us come to them and establish these clinics. They are sending word to us asking us to come to them. The idea is popular out our way, and I believe it is doing a great deal of good. I hope Dr. Briggs will hereafter add Michigan to the states he has already named as doing work in this line.

DR. BRIGGS.—Mr. President, I referred to out-patient departments as a state policy and my remarks should be regarded as applying to that proposition only.

THE PRESIDENT.—This work is actively progressing in the state of New York. Every hospital of this state caring for the insane has its out-patient department, and considerable embarrassment has arisen from the fact that our clinics are simply overwhelmed by the numbers of patients calling for advice in regard to treatment.

During the past month in our city of Binghamton, every Monday afternoon our clinic has cared for many patients and the members of the hospital staff who have undertaken to carry it on have found it a serious task. We feel that unless the state comes to our rescue and gives us more money and more help we shall not be able to carry the clinics anywhere nearly as far as they should be carried in our part of the state. I think Dr. Pilgrim might give us some information on this subject as Chairman of the New York State Hospital Commission.

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DR. PILGRIM.—Mr. President, I can only say that every hospital has from one to four clinics of this kind. At Poughkeepsie they have one in the city itself, another at Peekskill, one at Mt. Vernon, and we are about to start another in Yonkers. As Dr. Wagner says, the great trouble is that owing to vacancies on our medical staffs we are unable to meet the demands which have been urgently placed before us. We could, if we had a sufficient number of physicians, conduct, with success, a clinic or an out-patient department in every city of the state; but we are now so short of medical men as to make this impossible.

DR. BRIGGS.—Mr. President, I would like to ask Dr. Houston to say a word about starting these clinics; how after starting one or two he had applications to start others.

DR. HOUSTON.—Mr. President, the Northampton State Hospital holds clinics, one each week, in three cities besides at the institution itself. Many cases are seen at these clinics that would never come to the hospital, and our sphere is thus widely extended. Furthermore, the public has shown its realization of our intent and efforts, and thus the hospital has been placed on a better footing with the public. This was discussed so thoroughly at out meetings a year ago that it hardly seems advisable now to repeat what was said at that time.

I beg to say that I cannot agree with Dr. Stearns that the study of medicine or practice of medicine unfits a person for the position of social worker. It may be true, as Dr. Stearns' experience, has shown, that non-medical persons may have a special adaptability for such work, but if such adaptability is also possessed by a medical person, such individual is correspondingly better fitted for the position of social worker in a state hospital. The social worker mentioned by Dr. Stearns seems to be able to make "snap diagnoses" of mental cases. She would be better able to make diagnoses if she were a physician with several years of experience.

The Northampton State Hospital was one of the first in the country to employ a woman physician for this work, the date being October, 1911. Undoubtedly there have been others who began earlier, but this was one of the earliest, and I have yet to find a social service worker more capable than the officer mentioned, not because she is a medical woman necessarily, but because there is combined in one individual an adaptibility to do social service work with the qualifications and experience of a medical officer.

DR. STEARNS.—Mr. President, just a word about the expense. I believe the average cost of out-patient work varies from 18 cents to 57 cents per visit. Our work has cost more than that; it has averaged $1.50 per visit. Of 9200 visits some of which were not more than five minutes in length, the average cost to the state was $1.50; so that there is something to be said along the lines of economizing and yet this appears to be greater economy than State Hospital care.

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As to the social service work, I believe physicians make very good social service workers, and medical training is an excellent background. I have no difference with Dr. Houston in this regard. I merely wanted to say that it was perhaps too much to ask a person to go through a medical school in preparation for social work; that physicians doing all sorts of work could not do better in this line than others, and I think social service work can be done by a less highly trained and less expensive person.

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PSYCHOPATHIC BUILDINGS AND RECEIVING SERVICE.

By CHAS. A. BARLOW, M. D.,
Superintendent Spencer State Hospital, Spencer, W. Va.

One of the chief problems of the state hospital is the treatment of the acute, curable psychosis. Ever since the days of Pinel, our profession has been wrestling with this problem. The disease idea of insanity has developed hospital care and nursing of the disease year by year until about 1880, when Dr. Clouston advocated and adopted separate hospital wards in the Morningside Institution. From that time to the present the advisability of hospital wards for receiving cases has met with favorable recognition. During the past 10 years many of the state hospitals have added the detached buildings, until now there are about 15 per cent of them so equipped. In recent years psychopathic wards have been established in connection with the general hospitals in the larger cities and are doing very valuable work. There have been established psychopathic hospitals in connection with universities, such as the Ann Arbor, Boston, Phipps Psychiatric Clinic, etc.

For convenience of description I have made the following classification:

1. Receiving wards in state hospitals.
2. Psychopathic wards in general hospitals.
3. Psychopathic hospitals.
4. Psychopathic buildings in connection with state hospitals.

RECEIVING WARDS.—I merely want to mention these as some officials think they have real receiving service, when certain wards are designated in this manner. I hope later on to show the superior advantages of detached buildings for this purpose.

PSYCHOPATHIC WARDS IN GENERAL HOSPITALS.—The excellent work done in Albany, Bellevue, St. Francis and other general hospitals having psychopathic wards is so well known that I will not take up your time in discussing this subject further than to say that at least one general hospital in every metropolitan center should have a well-equipped psychopathic department.

Where the government or state maintains a medical school it is of course incumbent upon the authorities to provide a psychiatric

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clinic. In the past, too little attention has been paid to the subject of nervous and mental diseases in our medical schools, due largely to the want of material for clinical purposes. If we expect the medical profession as a whole to co-operate with us in the work of prophylaxis in mental disorders, we must have them educated along this line. While we feel that the greatest field for doing prophylactic work is among the alcoholic and syphilitic cases, yet we cannot accomplish much without the assistance of the medical profession and the public. The early recognition of the psychosis by the family physician and his co-operation in securing an early commitment will assist us very materially in increasing our recoveries.

PSYCHOPATHIC BUILDINGS IN CONNECTION WITH STATE HOSPITALS.—Most states could ill afford to erect independent psychopathic hospitals with their expensive equipment and extra cost of separate management, in addition to the larger institutions now in existence. Therefore, the detached hospital building in connection with these institutions has become the recognized solution of the difficulty. As mentioned in the beginning of our paper the chief problem for the state hospital is the treatment of the acute curable psychosis.

The advantages of psychopathic buildings in the solution of this problem may be briefly stated as follows:

1. Creates a better impression with patient and public.
2. Affords efficient treatment under most favorable conditions.
3. Offers better facilities for the study and classification of new patients.
4. Is an inspiration to staff and nurses.
5. Offers better opportunity for training staff and nurses.
6. Facilitates the transfer of patients to and from the larger institution.
7. Offers a more economic arrangement for carrying on work when the final results are taken into consideration.

When the public shifts its view of the state hospital and comes to regard it as a real hospital for the treatment and possible cure of an affliction, which is not a disgrace, it will co-operate with us more fully in our work. The tendency in the past has been to avoid the hospital until the very last moment, when perhaps the only chance for recovery has departed. By the use of the term

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psychopathic instead of receiving building we will at once arouse the attention of the public into making inquiry as to the character of this department. This will give us an excellent opportunity of explaining the features and advantages of same, which is bound to create a good impression. That much valuable time is often lost before the patient reaches the state hospital cannot be denied. It is also true that unfavorable conditions and surroundings at the very onset of a psychosis may at least in a certain proportion of cases cause serious damage and possibly retard recovery. During what we term the pre-insane period the patient has an insight into his condition and is more or less conscious of impending trouble, and oftentimes seeks relief, and especially when he can do so, by entering a hospital instead of an "asylum." The first impression made upon a patient oftentimes influences the course of the psychosis, and may even destroy all hope of recovery. The new arrival when ushered into the hospital for the initial bath and examination will be impressed with the hospital idea, and even though not physically ill will not offer resistance to the treatment outlined by the physician-in-charge. The overcrowded condition of all state hospitals and the large capacity of receiving wards will leave many chronic or institutionalized patients upon same, which will not have a very beneficial effect upon the mild, acute case. Of those who recover and return home their impression of the institution and its work will be far in advance of what it would have been had they been cared for in the old receiving ward.

A small properly equipped building will afford better opportunity for study and classification of these new patients. Under the old system where you had several hundred patients mingled together there is a liability of overlooking some of the acute and recoverable cases.

By being removed from the sight and sound of other and more objectionable types of insanity he is placed in a position more favorable for treatment.

With facilities equal to those found in the best general hospitals for the treatment of physical disease and the hospital atmosphere will bring about excellent results.

Hydrotherapy, electrotherapy, medicinal treatment, massage, good nursing and dietetic management in such surroundings will produce better results than when conducted in wards containing

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other classes of cases or closely contiguous wards. With such facilities the medical staff will have every opportunity for the proper classification and study of these cases, which is bound to bring about very pleasing results. The staff will enter upon their duties with new inspiration and energy. In a like manner the nurses in charge will enter the work with enthusiasm on account of variation in the class of patients found in this department in contrast with those found upon the main wards of the institution. New and interesting cases will be continuously passing through these wards and will bring forth their keenest power of observation and good nursing. The pupil nurse should spend a certain period upon these wards, as the work is more attractive and offers an excellent opportunity for proper training. Our experience has been that new nurses placed on the violent or demented wards will soon become discouraged and quit the service. With the hospital idea foremost she is stimulated into deeper interest in her work, and, if intelligent, soon becomes proficient and is available for service in any department of the institution. The advantage of having a detached building upon the same ground instead of a separate institution reduces the expense of transferring patients to and from the larger institution and they can be made more readily.

Location and Type of Building.—This building should be entirely detached from the main institution. Some writers recommend a connecting corridor or subway, but in my opinion the use of either is not advisable, not more so than would be the connecting of cottages by such a method. It should be of a size proportionate to the number of first admissions during one year. By all means it should be of limited capacity so there would be no temptation for keeping chronic or other undesirable patients upon these wards. For the smaller institution it could be built for both sexes with a single diet kitchen and hydrotherapy equipment, with the exception of continuous bath. To describe what we would consider the proper building for an institution of 1000 population, would be to outline our present building, which was decided upon after examining many plans and consultation with several superintendents having this service. This building has a capacity of 74 beds, or 37 for each sex. It is 42 x 150 feet and two stories high, with basement partly above ground. A solid central wall separates the two departments with the exception of hydrotherapy rooms which

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are for use of both sexes. For each department we have provided the following rooms: Office, reception, examination, two dormitories, 14 single rooms, two sun rooms, continuous bath, dining-room, toilet, lavatories, clothing, six utility and one occupation room. For the entire building we have provided hydrotherapy rooms, diet kitchen and serving room. You will note that we have omitted the operating room and laboratory, which rooms are in the administration building. We cannot see the advantage of having these rooms in this building as the physically sick occurring within the main institution are cared for upon special wards used for that purpose. We do not approve of the idea of combining the sick hospital with the psychopathic wards. You will also note that we have a large number of single and utility rooms which were added upon the advice of several superintendents. This building was erected by our own force at a cost of $25,000 which may appear impossible or that we have an inferior structure, upon the contrary I can assure you that it is equal to the average psychopathic building in connection with state hospitals. All superintendents appreciate the difficulty they have in securing additional buildings and especially those of limited capacity and we had the same trouble, and it was only after persistent effort that we secured an appropriation of $15,000 for this building. This amount would appear very small to those who are accustomed to receiving liberal appropriations. However, we were extremely anxious to obtain this service and even before the appropriation was available we had completed the excavating and bought the material for this building. We merely state these facts so that other superintendents may be encouraged in their efforts with legislators and boards of control, in securing these valuable additions to their institutions. In the construction of this building particular attention was paid to the heating, lighting and ventilating equipment. While steel sash were used no guards are to be found in the building, in fact we tried to make it appear as nearly as possible like a general hospital.

Medical Service.—In a compilation of answers to a questionnaire sent out by the National Committee for Mental Hygiene, concerning psychopathic hospitals, wards and buildings, of the 47 replying only six had special clinical directors: Agnew of California, Springfield of Maryland, Manhattan of New York, St.

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Elizabeth of District of Columbia, Oregon State and Taunton of Massachusetts. While we realize there would be some advantage in having a special clinical director, yet we feel that the extra cost of such officer would hardly justify the same. In justice to the regular staff they should all serve a period in this department, and at least one member should be on duty at all hours. You will find that the members of your staff will devote more time to study and take more interest when given the responsibility of this department rather than being merely assistants and depending upon a clinical director or superintendent. By this method you will not only train your staff in the work, but obtain the benefit of their study and knowledge of the subject.

NURSING SERVICE.—Next to the medical service naturally comes that of nursing, and you should by all means have in charge your most skilled nurses. While we doubt the advisability of probationers serving upon these wards, yet we feel that all pupil nurses should spend a certain period in this department. Their service in this building should begin immediately after the end of a probationary term of one month. There should be female nurses in the male department and we find only two institutions in the whole list who have eliminated the male nurse in this service. They are the Peoria State of Illinois and Independence State of Iowa.

KITCHEN AND DINING-ROOM SERVICE.—It is absolutely essential that the dining-room service be independent of the main hospital. As to the kitchen service we find it is more economical to serve from the general kitchen, and have provided a diet kitchen for those requiring dietetic treatment. This last feature we believe to be absolutely necessary in the maintenance of these departments.

In conclusion I wish to repeat that in my opinion the most effective method that can be devised to improve the condition of the insane is to bring about a more enlightened public opinion. The first and most important step is to begin in our own ranks and aim to bring our service up to the highest standard. In the establishment of psychopathic buildings in connection with our state hospitals we are not only doing this, but we are advancing the study of mental disorders, which will bring about greater results in the end. We hope in the near future that no hospital for the insane will be considered complete without such a detached and fully equipped building.

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THE RECEIVING UNIT OF THE STATE HOSPITAL AT HOWARD, RHODE ISLAND.

By ARTHUR H. HARRINGTON, M.D.

The receiving of a newly committed patient into a large public hospital for the mentally sick is a procedure which should receive a discriminating and orderly attention. This procedure should have certain definite objects in view. Among the aims to be striven for during the earliest hours following the entrance of the patient should be the orienting of the patient, as far as the mental state allows, towards new and strange surroundings; the endeavoring, as far as the susceptibilities of the patient permit, to direct the reactions arising from changed circumstances into channels leading to a rational view of the situation; the determining, at the earliest possible moment, the immediate condition and needs of the patient; and so managing all these acts as to give the greatest degree of protection to the patient and to the hospital as well, and satisfaction to the friends of the patient.

The place, the manner of reception, and the technique followed during the first hours of a patient's residence should be calculated to produce a favorable impression upon the patient, if possible; these should all be of such character as to keep the suggestion before the patient that he is in fact a patient in a hospital, where he may, if able, comprehend that hospital methods are being carried out for his own good.

The practice relating to the first attentions given to the newly arrived patient from the moment he enters the hospital doors must necessarily vary in detail in different hospitals, according to various circumstances. A factor which may produce variations in these practices may be attributed to the diversity in hospitals as relates to the plan and the general scheme of the buildings. For instance, the block plan, so called, of hospitals for the insane so much in vogue at one time presents some limitations when we try to organize in a hospital so planned a distinct receiving service. The cottage plan of hospital buildings offers better means for the organization of a receiving service which shall have a certain degree of separation from the general service of the whole institu-

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tion. As a development of the cottage plan of buildings around an administrative center, we have instances of provisions for convalescents, epileptics and tubercular cases in buildings or units by themselves grouped around the administrative center.

There seems now to be a movement, not so entirely new, but apparently growing in favor, for the establishing of what is called, from the service to which it is put, the "reception hospital," by which is understood a building more or less separated from and independent in its organization of the main hospital plant for the reception of the newly committed cases. I say more or less separated, for this differentiation of the reception hospital from the main hospital plant, physically and from the standpoint of administration and organization, may vary widely in different institutions.

My reasons for responding to an invitation to present a paper at this meeting is because we are beginning to hear the reception hospital discussed as a feature of hospital planning, and because I believe that we have at the State Hospital for Mental Diseases at Howard, R. I., as complete an example as can be found of a building for reception purposes, embodying the features of a service devoted solely to the reception and treatment of recently committed cases of mental disease, a department of the main hospital, located upon the grounds of the main hospital, but conducted as far as conditions will permit as an independent unit.

In describing this receiving unit I will first speak of the building itself.

The building occupies a commanding position upon rising ground and has a southerly exposure. It is separated from the grounds of the main hospital by an avenue. The long dimension of the building, east and west, is 451 feet. The structure contains a central section, on the east of which extends the wards for women and on the west those for men. At the center of the central section, on the south front, is located the main entrance, having a porch and driveway entrance protected by a porte-cochère.

The first floor of the central section contains reception and admission room and necessary offices for the physicians of the receiving service and for stenographers. On the second floor over these rooms are the living quarters for the physicians of the receiving service. In connection with these quarters there is a

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dining-room where the physicians have their meals. The third floor contains rooms for nurses, orderlies and domestic help. The nurses' school-room is located upon the second floor of the central section, and the third floor of the central section has commodious hall space which is furnished as a sitting room and meeting room for the nurses.

The surgical department and operating room is located on the first floor of the central portion north of the hallway. This portion is one story in height and is well lighted by north windows and overhead skylights. Here are located sterilizing room, preparation room, etherizing room and general supply room, the latter for surgical and medical supplies only.

In the central portion also is a large platform elevator, arranged for hospital use and which can accommodate a wheel stretcher. The elevator travels from the basement to the third floor. In the basement of the central portion is a kitchen in which is prepared all of the food for patients and employees, with the exception of bread and such food as requires baking in the bake ovens of the institution. On either side of the kitchen are dining-rooms for nurses and employees. In this basement is a small laundry where nurses and employees can launder such clothing as they choose to do themselves.

As stated above, the wards for women extend to the east of the central section and those for men to the west. The plan of the building for both men and women is alike. Each side consists first of a two-story section occupied by wards and day room, and on the extreme ends of these sections are disposed, at right angles with the long dimension of the building, two wings of three stories containing single rooms for patients on the first and second floors, dormitories for patients on the third floor and a few rooms for employees on this third floor.

At the right and left of the admission rooms on the first floor are disrobing rooms and baths, one for men and one for women, which are used for incoming patients for the initial bath. Opening immediately out of each bath is a chamber in which the patient is placed in bed immediately after the bath and where a preliminary examination of the patient is made at once. This preliminary examination consists in a careful examination of the body externally, making note of all marks, bruises, injuries, or peculiarities,

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and a physical examination which will insure information as to whether the patient has any fractures or whether physical disease is apparent. In a brief examination an attempt is made at this time to gain a general idea of the patient's mental state and attitude. The physician then assigns the patient to a ward or room on the wing and a statement of the preliminary examination is passed at once to the typist for record.

Opening out of the hallway of the central section on the first and second floors and adjoining each ward is a dining-room for patients with a connecting serving room to which food is conveyed from the basement by means of dumb-waiters. There are four of these dining-rooms, each having a seating capacity equal to the capacity for patients of each ward.

There are four wards, two for the men's side and two for the women's side, but each ward is subdivided in such way as to provide for the classification of incoming cases according to their condition. There are two sections in each ward, each containing 10 beds. Between these two sections is a day space. On the front of the bed section are out-of-door sleeping balconies, arranged to be open in summer and closed or partially closed with glass in winter. These spaces can be warmed by direct radiation. These so-called sleeping balconies contain five beds each and there are eight of them upon the building. Passing on one comes to the single-room section in the extreme wing. Each floor contains 10 of these rooms. These rooms are especially provided for disturbed patients and those who are unsuitable for the general wards. These single-room sections are closed off from the general wards by partitions having wire-glass panels in the upper portion and wire-glass panels in the upper portion of the doors. In connection with the single-room section, exposed to the south, are sun rooms. Connected also with each single-room section is another sleeping balcony containing four beds.

The dormitory upon the third floor of each extreme wing has accommodations for 18 beds. This dormitory was included in the plan for the purpose of providing a place for 18 men patients and on the women's side also 18 women patients of the quiet and orderly class who would assist in the work of the hospital.

Each ward has a total of 44 beds. Together with the dormitory accommodations there is a total of 212 beds for patients. There is

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accommodation besides for 40 employees, physicians, nurses and other help.

Each ward on each floor is provided with lavatories arranged to serve both wards and sleeping balconies; clothes rooms; linen rooms; and utility closets.

In the extreme wings are located the general bathing facilities. For the general bathing, shower-baths are provided. There are tubs in the water section at each end of the ward for patients who are too feeble to receive shower-baths and for uncleanly patients.

Between the wards and the single-room section is an iron stairway enclosed in brick, which serves the purpose of general traffic and also as an enclosed fire-escape.

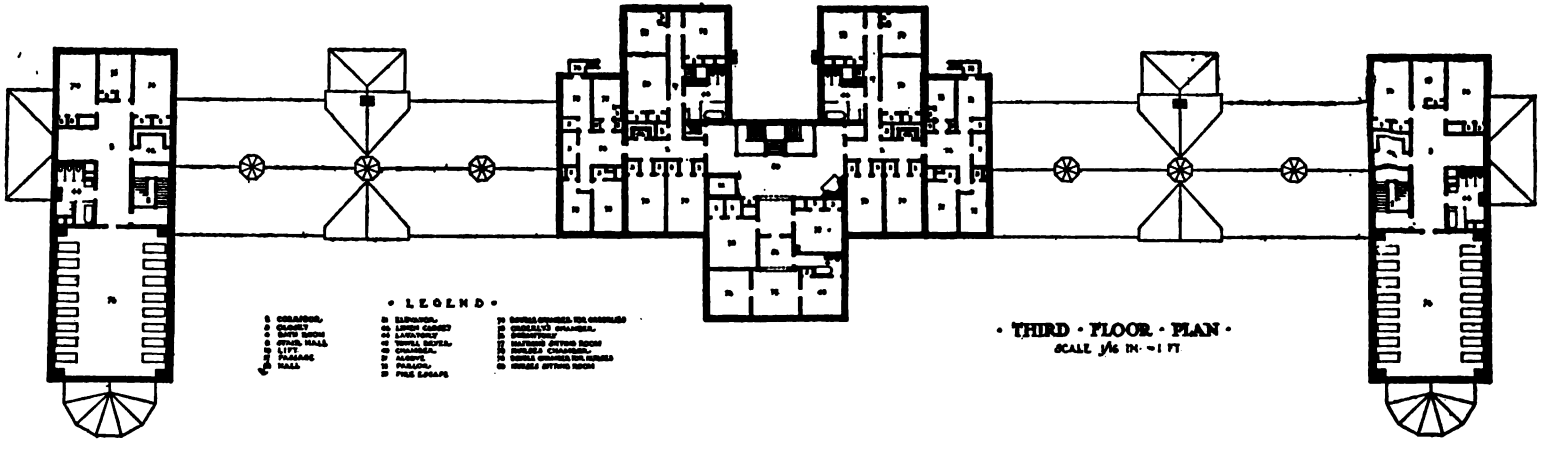
In the extreme ends and in connection with the single rooms are located the tubs for continuous bathing, four for the men's side and four for the women's side. It has been our experience thus far that four tubs are sufficient for the men's service, but that most of the time we need eight tubs for the women's service and there are occasions when we could very well use 12 tubs for women. The basement of the building extends well above ground, affording well-lighted rooms. In the basement are rooms for hydrotherapy. Here are located also the pathological laboratory, and mortuary and post-mortem rooms.

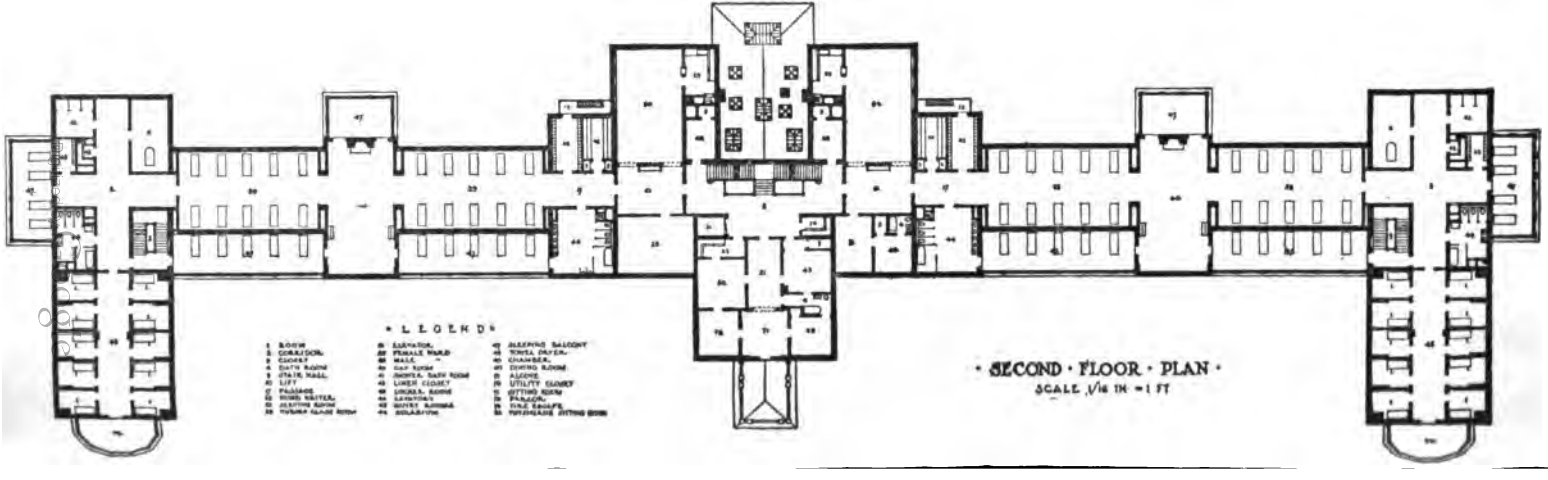
The method of heating is both direct and indirect. The indirect heating is by means of stack rooms in the basement, the warm air being forced into the wards by fans, the motive power of which is electricity. The heating is furnished by the central boiler plant. The lighting is by electricity. The lamps in the patients' wards and departments are so controlled by a series of switches that they can be brilliantly or very dimly lighted. All ward lights are enclosed in white porcelain globes, so that no direct rays from the lamps meet the eye.

Throughout the building there is a total of 80 beds on wards for patients; 56 beds are distributed in the sleeping balconies; there are 40 single rooms and 36 dormitory beds, making the total 212 beds.

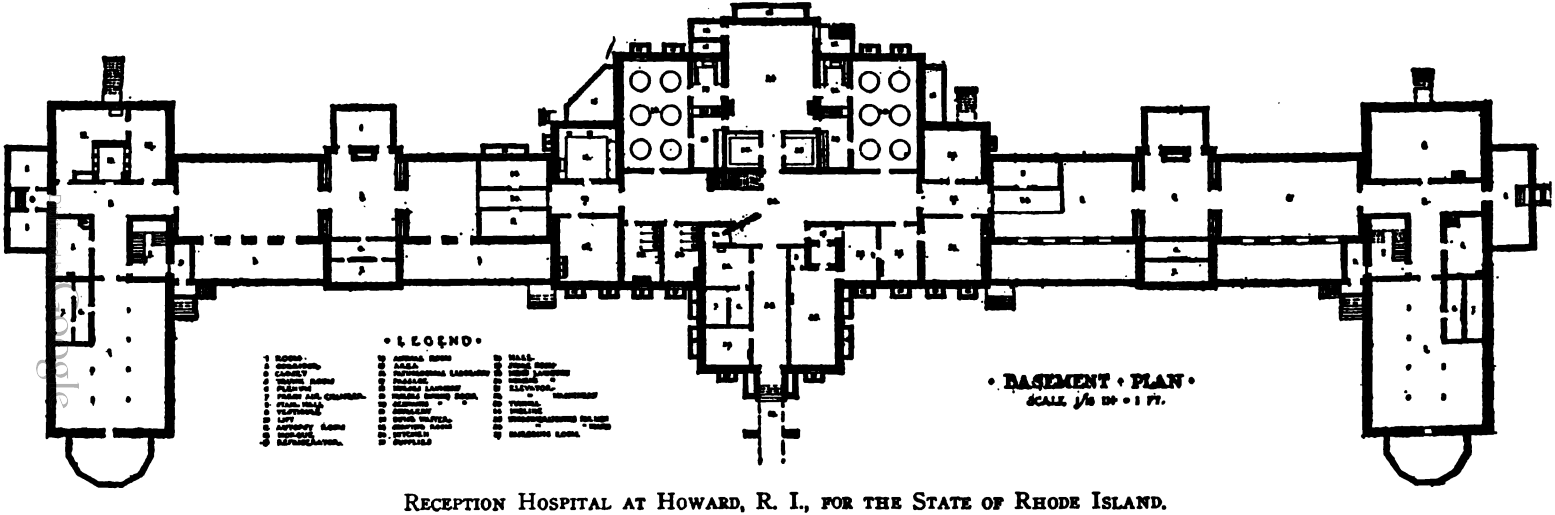
The construction of this building was begun in 1910 and finished in 1912. The total cost of the building with all connections, equipment and furnishings was $326,000. The cost per bed per patient, everything included, was $1537. It will be borne in mind

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RECEPTION HOSPITAL AT HOWARD, R. I., FOR THE STATE OF RHODE ISLAND.

that besides providing for patients we have made accommodations for 40 officers and employees.

The domestic work of this unit is in charge of the assistant housekeeper, under the direction of the dietitian and housekeeper of the main hospital plant.

The reception hospital is in the immediate charge of an assistant physician, who is the head of the department. He has two medical assistants. The physician-in-charge is responsible to the superintendent of the hospital for the conduct of the whole reception hospital unit, for the proper reception and treatment of patients, and for the proper maintaining of all discipline. In fact he has the sole charge of the reception hospital and the receiving service and stands practically in the same relation to the superintendent that a superintendent does to his board of managers. The superintendent of nurses is responsible to the chief assistant physician primarily for the nursing care of the patients in the receiving service and for the conduct and discipline of the nursing service.

The nursing of the wards is in charge of graduate nurses, one graduate nurse being in charge of each ward, and this is true of the men's wards. Under the charge nurses are the pupil nurses. There are pupil nurses on the men's wards; the male employees on the men's wards who perform attendants' work stand in the same relation to the charge nurse as orderlies in a general hospital.

The daily medical work of the reception hospital and the entire care and responsibility for the patients on the receiving service rests in the hands of the three physicians assigned to this service. The remaining physicians on the medical staff, namely, those who have services in the main hospital, are related to the receiving service as follows:

In the order in which they are admitted all incoming patients are assigned in rotation to each member of the medical staff, whether on the receiving service or on service at the main hospital, for the purpose of making the critical physical and mental examination and presenting the case before the clinic. In this way although the physicians of the main hospital may have services on which the patients are of the chronic class, yet by means of this plan they are brought in contact constantly with the new and acute cases.

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The superintendent of the hospital does not have offices at the reception hospital. The medical records of the patients are retained at the reception hospital as long as the patient remains there. As soon as the patient is paroled or is transferred to the main hospital the medical record is filed in the office of the main hospital. There is filed at once, however, at the main hospital, an index card, containing the usual information of such card together with the addresses of relatives and friends. As soon as a case has been presented at the clinic a blank, which is a symptom index, having been filled out at the time the patient was presented to the clinic, and which has had checked upon it physical and mental symptoms which the patient presented at the time of the examination together with the diagnosis and opinion of each member of the medical staff, is filed at the main office.

All correspondence relating to patients in the receiving service passes through the hands of the superintendent. Practically all inquiries by telephone and by visitors are answered directly by the physician in charge of the receiving service or his assistants.

The first floor of this hospital contains the admission wards. The second floor is for convalescents, or for patients who can shortly be transferred to quiet wards. An admission rate of 500 annually and 212 beds allow an average of 22 weeks' residence in the reception hospital for each patient admitted. After the critical study of the patient has been made and he has been presented at the clinic for diagnosis, if an organic case or manifestly chronic or senile, the patient may be transferred at once to a ward of the main hospital. An acute and apparently curable case is retained in the receiving service or convalescent wards of the building as long as there is reasonable hope of recovery. The aim is that all recoverable cases and those who show marked improvement shall not at any time be transferred to the main hospital, but shall be paroled from the reception hospital. With the exception of surgical cases no transfers are made from the main hospital to the reception hospital, all patients at the main hospital who are ill being cared for in the infirmary wards of the main hospital.

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DISCUSSION.

DR. HILL, of Maryland.—Mr. President, even at this late hour it has been interesting to hear these details of hospital administration. As to their designation probably a psychopathic hospital or ward is as good as any. A good old lady always wept when her minister preached a certain sermon and when asked why, said "the beautiful way you pronounce the word Mesopotamia always brings tears to my eyes." While psychopathy means nothing more nor less than insanity it has a decidedly classic ring and in the minds of the public suggests something out of the usual. But the chief advantage of such building as the doctor describes with its high sounding name, is that in the lay mind it is a kind of neutral ground between the sane and the insane world and one is less reluctant to send his afflicted friend to such a hospital than an asylum for the insane. With this object in view we might go further and call it a neuropathic hospital. It is quite fashionable to boast of being nervous and the gentle sex who some think are destined to rule the world, delight to match their nervous symptoms when they meet, making insanity popular, or at least less objectionable by giving it a more attractive name would present very obvious advantages. Another suggestion is to establish these hospitals more remote from the well-known state institution, even in the adjoining town; if not too distant for the supervision of the superintendent. This would at least tend to bridge the gulf between sanity and insanity and render the placing of the mentally disturbed under proper treatment easier for the patient and the family.

DR. HARRIS.—Mr. President, the three papers which have just been read are very important and they cannot properly be discussed within the limitation of the time fixed by the association. The questions brought up are those in which I have been very much interested for a number of years. I was specially interested in the paper by Dr. Harrington, and the illustrations thrown upon the screen. It was a most excellent presentation, and without any intention of making criticism, I would like to make some suggestions. I notice there is no arrangement made in the reception hospital for out-door clinics or any special examination rooms for the eye, ear, nose, throat and teeth, which seem to me to be very important. One objection I would make to the reception hospital as shown by Dr. Harrington, is the location of the autopsy room and laboratory. They should be disconnected. I think where large and airy basements are constructed, they should be used as recreation rooms, especially in cities, where there is lack of ground for proper recreation activities and entertainment. This space should be used for that purpose, where no arrangements for roof gardens are made. One thing I like about the construction mentioned by Dr. Harrington, as well as Dr. Barlow, is the use of porches for special sleeping space for special cases. That is most important. Another very important point is the breaking up of patients into small groups. We all know that where a patient has been put on a ward with a hundred or more patients, with the lack of help to give individual attention to

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that particular patient, it cannot fail to result in damage, and that is where we fail to do our duty. In the organization of a hospital service of this nature, it seems to me there should be a clinical director to direct the work of the staff, to see that active and intensive treatment is given to each and every patient, to see that proper histories are procured and all facts about the case properly entered. There should also be an expert pathologist, who should attend to all the pathological work, and with the assistance of the clinical director, correlate all the facts so that they may be useful, not only to the staff, but to the profession at large. It seems to me we would gain a great deal by this procedure. A great deal of material goes to waste without benefit to the general profession. We should work with the general profession and medical colleges as far as possible—and thus we revert to the discussion of this morning, that of having psychiatry and psychopathology taught in the medical colleges; that medical students should be brought to this hospital and given advantage of the study of the large amount of material at hand. We should also use as coordinate factors in our work the social workers of the community, mental hygiene committees and charity organizations and bureaus. Public lectures should be carried along in conjunction with this so that we may spread abroad all possible information upon the subject in question.

These remarks would apply also to the first paper on social work among those suffering from mental disease. Concerning the use of the word "insane" I would make every effort to eliminate its use and substitute "mental disease" or "psychosis."

DR. MITCHELL, of Brockville, Ontario.—We have reached so late an hour and already a great deal has been said on this interesting subject, so that I shall not make any extended remarks.

At our hospital in Brockville, Ont., we opened a reception hospital last August. The idea was conceived by Dr. Forster, at that time superintendent, and who is now in Toronto. He drew the original plans of the hospital which, however, were considerably altered and many changes were made. Our reception hospital is not so large as the one which Dr. Harrington has shown us on the screen, but we have 60 beds and our total population is about 800 so that it reasonably meets our wants. We have solar rooms which are similar to the rest rooms described by Dr. Harrington. We find them very useful indeed for general treatment. We have very wide enclosed verandahs that are in constant use both for exercise and fresh air for the patients and also as dormitories when needed. These are fitted up with glass for winter but no heat is provided, but that does not prevent them from being very useful. Our reception hospital has not been in operation very long but it fills a want which we had for a long time.

Our Ontario law has been changed so that now voluntary patients can be admitted. We have a considerable number of these and the reception hospital permits us to keep patients more closely under observation and we can also give them more individual attention than we formerly could.

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We are very short of physicians on all staffs of the Ontario Hospital at present, as nearly every available man has gone to the front. I have been left with an Assistant Superintendent, Dr. Forster also has an Assistant Superintendent with one or two juniors, Dr. English has two, Drs. Robertson and Beehmer have lost their Assistant Superintendent and the Superintendent himself at Kingston has been overseas. These men are all doing psychopathic work in the various hospitals in France and England. At the present time there is not a medical graduate in Canada who can go into service in the hospitals, as they have all, both last year and this, gone into military work.

The reception hospital is a very excellent idea and anyone who is able to establish one will find it of great value.

DR. OSTRANDER.—Mr. President, I was very glad to listen to the papers and the discussion. But it surprised me very much to learn that the idea is considered at all new. In Kalamazoo we have had detached hospitals for the intensive treatment of cases of insanity for the past 15 years, and we have segregated our acute cases for 20 years. The method is good for the patient; good for the physician and an excellent thing for the nurses—a good thing all around and from long experience I can recommend it, and I certainly hope that the ideas mentioned in this paper will be generally adopted.

DR. HARRINGTON.—Mr. President, I want to agree with what Dr. Barlow has said about transfer of sick patients from the main hospital to the receiving hospital unit. I think that such practice interferes with the efficiency of receiving service and detracts from the aim of conducting such service as a separate unit.

With a complete surgical operating-room layout in connection with a reception hospital I think the only patients who should be transferred to it from the main hospital are such cases as require operative surgery.

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CERTAIN OF THE CLINICAL ASPECTS OF "LATE KATATONIA" WITH A REPORT OF CASES.

By EDWARD A. STRECKER, M. D.,
Assistant Physician Pennsylvania Hospital for the Insane, West Philadelphia, Pa.

Introduction.

The history of katatonia as written in the literature of the past 40 years is the record of a constantly changing conception, thus sharing the common fate of every disease or symptom which has been intensively studied. In 1874, Kahlbaum[1] published his masterly description of katatonia as a "disease-entity" of relatively favorable course and termination, embracing so-called "melancholia attonita," stupor and "acute dementia," as clinical variations of the same basic process. Motor disorders were emphasized as the essential feature. In the same year Arndt disputed the theory that Kahlbaum had uncovered a hitherto, undescribed psychosis. Sometime later Hack Tuke[2] referred to katatonia as a state resulting from "the exclusive direction of the mind on a melancholy subject," and in 1890, Bevan Lewis[3] dismissed it as one of the "multiple forms of hysteria."

All these and many more conceptions are echoed in recent contributions. So we find that to-day, katatonia is according to the trend of the particular observer, a disease process or merely a symptom, a strictly functional or an undoubted organic disorder, a somatic expression of toxicity or a psycho-pathological mechanism precipitated by a complex.

Katatonia and Katatonic-Like Symptoms.

The flattering attention which the general subject has received from every department of psychiatry and its related fields has naturally tended to widen the scope of its original application and perhaps in some instances has beclouded its true significance. Primarily regarded as essentially a motor or muscular phenome-

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non, as is indicated by the derivation from the Greek κατατεινω "I stretch tightly"—it has gradually been expanded and made to include the most varying forms of behavior—abnormality, of which mutism, scolding spells, impulsive violence, refusal of food and the stereotopies are fairly typical. As these and similar symptoms are not infrequently the sole katatonic representatives of certain clinical syndromes, which arise during the fifth decade and later and are often cited to substantiate a diagnosis of "late katatonia," the importance of weighing them in the balance of careful judgment at once becomes evident. It is not contended that such manifestations, as for instance, mutism or food refusal may not be distinctively katatonic in a given patient, the reservation is merely made that at times they are not katatonic at all and that when viewed apart from other considerations their interpretation must always remain highly problematical. Thus, the gradual extension of the list of symptoms which katatonia has been made to cover has greatly added to the difficulties of deciding which cases from the indeterminate group of psychoses encountered during the climacteric period and the pre-senium may be safely considered "late katatonia."

The array of so-called katatonic phenomena is truly formidable and there is scarcely a psychosis, organic or functional, in which one or more of them may not be discovered. Kraepelin[4] emphatically warns the clinician against the fallacy of endowing any single manifestation with diagnostic value, no matter how clear-cut it may happen to be. Any suspicious symptom or set of symptoms ought to be regarded not as katatonic, but as merely katatonic-like, until subjected to a rigid comparison test with the remaining symptomatic features and indeed with the *entire history and course of the psychosis in which they appear.* For instance, catalepsy, echolalia and echopraxia, grimacing or rhythmical movements and the like are not necessarily significant for katatonic dementia præcox unless they are accompanied by other signs and upheld by the general trend of the condition in which they are found. This thought seems especially applicable to the problem of "late katatonia," which occurs at an age when the more unusual forms of manic-depressive insanity, arteriosclerotic and other organic processes, and the presenile mental disorders are so frequently brought into question. It is all the more important because of the

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inclination to speak of "late katatonia" as a disease or at least as a more or less definite symptom-complex for which certain prognostic laws may be formulated.

The "Late Katatonia" of Urstein.

Urstein[8] regards "late katatonia" as a disease process rather than as a symptomatic expression. His exhaustive monograph is correctly designated a "clinical study" for it touches but very lightly on the pathological findings. His attitude toward the rôle which the autopsy and the microscope are to play in the solution of the problem is as distrustful and pessimistic as that of Kraepelin is optimistic and expectant. Urstein's "late katatonia" is an auto-intoxication disease whose etiology is to be sought in certain anaphylactic processes dependent upon the resorption of sex-cells or their products. The author himself appreciates the obstacles which stand in the way of applying this theory to a life epoch in which the sexual glands normally cease to functionate, but nevertheless maintains that the cessation of the strictly sexual function of the generative glands does not of necessity imply a complete stoppage of their metabolic activity. Further, he calls attention to the probability of a compensation on the part of the thyroid during the post-climacteric years.

From a careful study of 40 patients, Urstein has attempted to formulate a descriptive symptomatology for "late katatonia." To avoid useless repetition, I will simply indicate the general outlines of the composite picture which is presented, whose individual features are referable to three main symptomatic headings. First, general katatonic symptoms which characterize katatonia at any life epoch. Separately considered, these if perhaps somewhat more generous in their proportions, still do not differ essentially from the concepts of many other writers. However, particular emphasis is placed on the occurrence of so-called "contrast" or "disharmony"—"an inner dismemberment, splitting or doubling of the personality, along with retained mental clearness and orientation," which finds its expression in every imaginable contradiction of speech and act. In addition, optical illusions, and more particularly certain characteristic visual falsifications as a result of which the patient distorts both the animate and inanimate

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environment, are also emphasized as diagnostic landmarks.* The second group of symptoms are not katatonic at all and may be designated "epochal" in that they simply bespeak the influence of a definite time of life on the individual. They may be viewed as a pathological distortion in a psychotic subject of the physiological effect of such critical periods as adolescence, involution and the senium, and are apt to make their appearance in the course of any functional psychosis. They are, therefore, not in any manner peculiar to "late katatonia," nor in fact to any other form of mental disease, and are only of interest in that they happen to be coincident with the true and essential katatonic signs. For instance, distrust, suspicion and mild and fleeting paranoid trends occurring during the sixth and seventh decades are more significant for the approaching senium than they are for the special form of mental disease in which they come to the surface. The third set of symptoms are put forward by Urstein as in some sense diagnostic and specific for "late katatonia." The more important of these are certain types of parasthesia, due to a disturbance of subjective sensation and forming a basis for the greatest variety of the most senseless hypochondriacal delusions. Nihilistic ideas affecting the environment both as to place and person are quite common, but the one feature regarded as unique is the somatic-nihilistic delusion. The author asserts that among the functional psychoses this symptom is confined almost exclusively to "late katatonia" or that in any event it is never encountered prior to the period of involution. We have twice observed the somatic nihilistic delusion in early life. Once in a girl of 19 who showed many katatonic traits, but made a fairly good recovery. She refused to eat because her intestines were decayed and asked for a new head to replace *her empty one*. Again, a woman of 32, whose psychosis followed childbirth, is diagnosed manic-depressive and has a marked nihilistic trend, frequently expresses such

* As an example of such visual illusions may be cited the following: A patient glancing at a passing nurse notices that her face changes, becomes longer or shorter, the eyes begin to slant or the mouth to widen. At another time he may insist that the grass is blue or the trees dwarfed. We have observed this symptom in a dementia præcox patient, whose psychosis could scarcely be called katatonic at the present time and was at its height probably paranoid.

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somatic-nihilistic ideas as "my stomach and intestines were removed when the baby was born" or "my body is all dead. *I have no stomach*—nothing but heart and lungs."

As his diagnostic criteria are less rigid, Urstein's "late katatonia" is naturally more inclusive than that of Kraepelin and other observers. He embraces in his classification many of the circular and agitated depressions and practically all of the psychoses which Kraepelin prefers to retain with the pre-senile insanities until further clinical and pathological investigation can give them a more secure footing elsewhere.

Kraepelin's "Late Katatonia."

Kraepelin's "late katatonia" is in the embryonic stage. His attitude is distinctly one of "watchful waiting" and his final judgment always the same, namely "anatomy must decide." He makes his strongest statement in favor of the probable existence of the late psychosis when under the discussion of dementia præcox he observes, "there are undoubtedly cases which in the present state of our knowledge cannot be separated from the earlier forms and which we may designate as "late katatonia." During the involutional period the initial association of apprehensive excitement and melancholy delusions with certain katatonic manifestations, automatism, unapproachability, resistiveness and stereotopy, finally merging into a profound dementia is regarded as possibly, but not certainly, dementia præcox, influenced by a later than usual life decade. Among the rather heterogeneous collection of conditions considered under the heading of the pre-senile insanities there are a number of sub-groups which closely approach the "late katatonia" of other observers, but which Kraepelin cannot bring himself to place in the same category. In that class of patients in whom a depressive delusional trend with anxiety was gradually replaced by deterioration, such katatonic phenomena as posturing, a stiff unnatural carriage, rhythmical movements and mannerisms, affected speech, refusal of nourishment, resistiveness and unmotived excitement were all fairly common. Hypochondriacal delusional formation and the somatic-nihilistic idea, which Urstein would endow with such far-reaching diagnostic import, were also a part of the picture.

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Kraepelin decides against "late katatonia" principally on the clinical grounds of insufficiency, late appearance and doubtful character of the katatonic-like signs. A smaller group of cases beginning usually during the second half of the fifth decade with depression and hypochondriacal ideas, which soon gave way to an anxiety state with apprehensive delusions and such marked restlessness and motor activity as to give rise to the name "motility psychoses" and which in turn was finally replaced by a quiet, mild dementia. Kraepelin again declines to place the "late katatonias." He feels that the katatonia evidence offered by inaccessibility, resistiveness and monotony of speech and movement, is too meager to uphold this diagnosis. The fact that in three fatal cases Alzheimer's necropsy reports were not at all in accord with those of early katatonia, no doubt contributed to the decision against "late katatonia." A more difficult problem was presented by the few patients, who during the sixth and seventh decades developed a severe and long-enduring excitement and finally demented. They might have been fairly considered manic in view of the motor unrest and ideational productivity, which closely resembled flight and often revealed rhyming; paretic by reason of the characteristic, grandiose delusions, and katatonic on the strength of impulsive behavior, inaccessibility, echolalia, motion stereotopy, incoherent, disconnceted speech and light stupor. The absence of true negativism, hallucinations and distinctive autopsy findings, helped to turn the balance against "late katatonia." Thus, Kraepelin, cannot find among the pre-senile cases, a single instance which he is willing at present to transfer to the katatonic grouping.

BLEULER AND "LATE KATATONIA."

Bleuler[8] devotes but a few sentences to the subject and is rather inclined to be distrustful of "late katatonia" as a separate and distinct psychosis. He has seen no cases, in which the possibility of exacerbation or recurrence of an earlier condition which had become quiescent, could be positively excluded.

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An Analysis of the "Late Katatonia" in Twenty-Five Cases.

With the idea of analyzing "late katatonia" in its broadest clinical interpretation, not only as to frequency but also and more particularly as to its relation to the other features of any given case of mental disease, a review was made of the admissions for a two-year period including all the psychoses whose onset fell in the fifth, sixth and seventh decades. Of a total of 117 patients,* 25 revealed a strong admixture of katatonic-like phenomena; 17 of these occurred in the fifth, 5 in the sixth and 3 in the seventh decade. Occasional or very temporary manifestations were ignored and the katatonic-like factors in the appended table were generally pronounced, and frequently for a time, they were the dominant components of the clinical picture. The diagnoses given are an expression of the probabilities at present or on leaving the hospital. They are in no sense finalities, but merely deductions from the history, course and general clinical behavior to date. The table of cases follows this page.

Manic-Depressive Group.

Cases Nos. 1, 2, and in all likelihood, 3 were undoubtedly manic-depressive insanity, as evidenced by distractibility, flight and other manic features. The major part of the "katatonia" occurred in conjunction with freely expressed and strong persecutory delusional trends, and was practically always associated with marked irritability. It probably had its origin largely in these two factors. Refusal of food because of a belief that it contains poison, scolding or actively resisting the advance of supposed enemies and like reactions, are not at all an illogical expression of paranoid-persecutory ideas. When the connection between a delusion and a symptom, or set of symptoms, is not only clearly demonstrable but manifestly logical, as it seemed to be in these cases, true katatonia is extremely unlikely. In case No. 3, the stereotyped speech, fixed attitudes, grimacing, mannerisms and occasional mute periods, were the obvious accompaniments of frequent "trances" and were enacted by the patient in the rôle of a spiritualistic medium.

* A few cases of general paralysis and clearly established organic brain disease were excluded.

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MANIC-DEPRESSIVE GROUP.

Case No.	Age at onset.	Previous attacks.	Katatonic symptoms.	Affect.	Delusions.
1	40	None.	Unapproachability. Resistiveness. Violent scolding spells. Destructiveness. Impulsive violence. Food refusal.	Exhilaration. Frequent outbreaks of angry-irritability.	Persecutory and grandiose.
2	49	At 32 a 3-years' depression with suicidal attempts and violence.	Unapproachability. Resistiveness. Violent scolding and screaming spells. Destructiveness. Impulsive violence. Occasional mute periods. Mannerisms (?).	Exhilaration. Frequent outbreaks of angry-irritability. Occasional depressed periods.	Persecutory and grandiose.
	63	At 61 an excitement with recovery in 3 months.	Unapproachability. Resistiveness. Violent scolding spells. Destructiveness. Impulsive violence. Occasional mutism. Stereotopy of speech. Fixed attitudes. Grimacing. Mannerisms.	Frequent outbreaks of rage. Often irritable. Occasionally exhilarated.	Rather firmly held persecutory. Mild grandiose.

INVOLUTIONAL DEPRESSION GROUP.

4	42	None.	Resistiveness. Destructiveness. Impulsive violence. Food refusal. Mutism. Screaming spells. Fixed attitudes. Catalepsy.	Apprehension.	Hypochondriacal. Somatic. Persecutory (?).
5	40	None.	Resistiveness. Impulsive violence. Food refusal. Screaming spells. Stereotyped speech. Mutism. Peculiar attitudes. Grimacing.	Agitated apprehension.	No definite delusions brought out. Possibly some ideas of personal wrong-doing.
6	40	None.	Resistiveness. Food refusal. Screaming spells. Stereotyped speech. Mutism. Fixed attitudes.	Apprehension and agitated-depression.	"Unpardonable sin."
7	47	None.	Resistiveness. Food refusal. Monotony of speech. Mutism. Stereotyped movements.	Depression with apprehension.	Hypochondriacal. Vague paranoid-persecutory.
8	48	Depression at 24.	Unapproachability. Resistiveness. Destructiveness. Impulsive violence. Food refusal. Mutism.	Depression with apprehension. Irritability.	"Unpardonable sin." Hypochondriacal. Somatic. Paranoid-persecutory.

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MANIC-DEPRESSIVE GROUP.

Hallucinations.	Consciousness and orientation.	Duration.	Result.	Diagnosis.
None.	Fairly well preserved.	13 months. Followed by a mild depression lasting 3 months.	Recovered.	Manic-depressive.
None.	Fairly well preserved.	10 months.	Recovered.	Manic-depressive.
Auditory (?).	Fairly clear. Orientation defective for time and person.	11 months.	Unimproved.	Probably manic-depressive.

INVOLUTIONAL DEPRESSION GROUP.

None.	Clouded. Probably disoriented.	5 months.	Died of cervical carcinoma.	Involutional depression.
Probably none.	Fairly clear. Defective orientation.	15 months.	Unimproved.	Involutional depression.
Auditory. Visual.	Clouded. Disoriented.	19 months.	Died of lobar pneumonia.	Involutional depression.
None.	Fairly clear with confused periods.	7 months.	Improved.	Involutional depression.
None.	Consciousness and orientation both doubtful.	6 months.	Probably recovered.	Involutional depression.

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INVOLUTIONAL DEPRESSION GROUP.

Case No.	Age at onset.	Previous attacks.	Katatonic symptoms.	Affect.	Delusions.
9	42	None.	Resistiveness. Food refusal. Screaming spells. Speech monotony. Peculiar cramped attitudes. Mannerisms. Attempts to devour fæces.	Agitated depression.	Personal wrong-doing. Hypochondriacal. Somatic. Somatic-nihilistic. Paranoid-persecutory.
10	48	None.	Resistiveness. Food refusal. Fixed attitudes. Speech monotony. Mutism. Catalepsy. Stupor lasting several hours.	Depression with mild apprehension. Irritability.	Of personal wrong-doing.
11	49	"Nervous" attack at 40. Attack similar to this one at 48.	Resistiveness. Long-continued mutism. Fixed attitudes. Catalepsy. Three brief stuporous episodes.	Depression.	(?)
12	41	None.	Resistiveness. Food refusal. Stereotopy of speech and motion. Mutism. Fixed attitudes.	Depression.	Hypochondriacal. Somatic. Of personal wrong-doing.

DEMENTIA PRÆCOX GROUP.

13	41	None.	Unapproachability. Resistiveness. Impulsive violence. Destructiveness. Violent scolding spells. Mutism. Posturing. Mannerisms.	Emotional deterioration. Irritability most constant.	Paranoid-persecutory and grandiose.
14	47	None.	Unapproachability. Resistiveness. Impulsive violence. Destructiveness. Food refusal. Violent scolding spells. Mutism. Mannerisms. Statuesque and grotesque attitudes.	Apparent apathy and silliness. Often irritable.	Paranoid-persecutory and grandiose.
15	45	None.	Unapproachability. Resistiveness. Impulsive violence. Destructiveness. Fixed, grotesque attitudes. Mannerisms. Grimacing. Catalepsy. Neologistic formation.	Possibly exhilarated. Often apparently silly.	Indifferently held paranoid persecutory, hypochondriacal and somatic.

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INVOLUTIONAL DEPRESSION GROUP.

Hallucinations.	Consciousness and orientation.	Duration.	Result.	Diagnosis.
Possibly auditory and visual.	Preserved.	11 months.	Unimproved.	Involutional depression.
Probably none.	Fairly closely preserved.	22 months.	Unimproved.	Involutional depression.
Probably none.	Probably preserved.	14 months.	Marked improvement.	Involutional depression.
None.	Probably preserved. At times apparently confused.	3 years.	Unimproved.	Involutional depression.

DEMENTIA PRÆCOX GROUP.

Auditory. Visual.	Preserved.	8 years.	Unimproved.	Dementia præcox.
Auditory. Visual. Olfactory. Gustatory (?).	Moderately well preserved.	1 year.	Unimproved.	Dementia præcox.
Auditory (?).	Probably fairly well preserved.	9 months.	Unimproved.	Dementia præcox. Second choice, manic-depressive.

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DEMENTIA PRÆCOX GROUP.

Case No.	Age at onset.	Previous attacks.	Katatonic symptoms.	Affect.	Delusions.
16	46	Somewhat similar attacks at 43, 44, and 45.	Resistiveness. Impulsivity. Impulsive violence. Destructiveness. Posturing. Mannerisms. Light stuporous states. Mutism.	Doubtful. Often seemingly apathetic.	Paranoid-persecutory. Grandiose (?).
17	43	"Nervous" for 2 months at 38.	Resistiveness. Persistent food refusal. Monotonous speech. Mutism. Impulsivity. Catalepsy (?).	Depression with apprehensive phases. At times seemingly apathetic.	Paranoid-persecutory. Unreality. Somatic.

UNCLASSIFIED GROUP.

18	47	None.	Resistiveness. Food refusal. Impulsivity. Impulsive violence. Screaming spells. Monotonous speech. Posturing.	Apprehensive depression.	Paranoid-persecutory. Personal wrong-doing. Hypochondriacal.
19	61	None.	Resistiveness. Food refusal. Impulsive violence. Destructiveness. Mutism. Fixed attitudes. Mannerisms.	Apprehension most constant.	Poverty. Negation. Somatic. Paranoid-persecutory.
20	62	None.	Resistiveness. Food refusal. Stereotopy of speech and movement. Mutism. Fixed attitudes.	Apprehension most constant.	Poverty. Paranoid-persecutory.
21	54	None.	Resistiveness. Destructiveness. Impulsivity. Impulsive violence. Screaming spells.	Apprehension most constant.	Hypochondriacal. Fantastic delusions of torture and death.
22	50	None.	Resistiveness. Unapproachability. Destructiveness. Food refusal. Impulsive violence. Mutism. Attempts to devour fæces.	Fairly well sustained apprehension.	Unreality and negation. Fantastic distortion of time, place, person and inanimate objects. Somatic. Somatic-nihilistic. Paranoid-persecutory.
23	52	At 42 an attack lasting several weeks, marked by severe scolding spells.	Unapproachability. Resistiveness. Food refusal. Impulsive violence. Scolding and screaming spells.	Doubtful. Sarcastic, ironical and very irritable. Some evidence of silliness.	Vague paranoid-persecutory.

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DEMENTIA PRÆCOX GROUP.

Hallucinations.	Consciousness and orientation.	Duration.	Result.	Diagnosis.
Auditory (?).	Preserved.	15 months.	Unimproved.	Dementia præcox. Second choice, manic-depressive.
Probably none.	Doubtful. Considerable confusion.	13 months.	Unimproved.	Allied to dementia præcox.

UNCLASSIFIED GROUP.

Auditory. Olfactory.	Confusion. Disoriented, especially as to place and person.	13 months.	Unimproved.	Unclassed. Involutional depression.
(?)	Clouded. Disoriented.	6 weeks.	Died of bronchial pneumonia.	Unclassed. Toxic (?). Arterio-sclerotic(?).
Auditory.	Clouded. Disoriented.	11 months.	Unimproved.	Unclassed. Arterio-sclerotic(?).
(?)	Fairly well preserved. At times confused.	7 months.	Unimproved.	Unclassed. Arterio-sclerotic(?).
(?)	Fairly clear. Often disoriented.	2 years.	Unimproved.	Unclassed.
None.	Fairly clear. Not oriented.	9 months.	Probably recovered.	Unclassed.

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UNCLASSIFIED GROUP.

Case No.	Age at onset.	Previous attacks.	Katatonic symptoms.	Affect.	Delusions.
24	58	None.	Unapproachability. Resistiveness. Food refusal. Impulsive violence. Destructiveness. Violent scolding spells. Mutism. Mannerisms. Negativistic. Stupor lasting 2 months. Automatic movements. Retention of urine and fæces.	At first apprehensive depression. Later marked irritability.	Of personal wrongdoing. Paranoid-persecutory.
25	51	A 6-weeks' attack at 40 with some manic features.	Resistiveness. Destructiveness. Impulsive violence. Food refusal. Monotony of speech. Mutism. Fixed attitudes. Stupor, at times negativistic, lasting 3 months and ending in death.	Agitated-apprehension.	Paranoid-persecutory and grandiose.

Involutional-Depression Group.

In the involutional-depression group, of which cases Nos. 4 to 12 inclusive, are fairly good examples, the prominent affective reactions were probably instrumental in the development of at least some of the "katatonic" symptoms. This seemed especially true in those patients in whom the apprehensive element, either alone or combined with depression, apparently reached degrees of maximal intensity. Various forms of resistiveness, seemingly impulsive acts, screaming, distortion and fixation of attitude, probably catalepsy and possibly stupor when they *appear in close association with moving, affective trends* may be at least theoretically viewed as expression movements for certain emotions. It has long been recognized that a strong wave of emotion, such as might for instance be produced by fear, automatically induces reflexive movements, probably of a defensive character, which are commonly regarded as evolutionary survivals. Spencer wrote: "Fear, when strong expresses itself in cries, efforts to hide or escape in palpitations and tremblings; and these are just the manifestations that would accompany an actual experience of the evil

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UNCLASSIFIED GROUP.

Hallucinations.	Consciousness and orientation.	Duration.	Result.	Diagnosis.
Probably none.	Probably preserved.	11 months.	Unimproved.	Unclassed.
Auditory.	Confusion. At times fairly clear and oriented.	29 months.	Died of pulmonary edema.	Unclassed.

feared."[9] There is no good reason for believing that here the same factors may not be operative in the insane as in the normal—indeed it is possible that in patients suffering from mental disease, in which reality is in a large measure swept aside by delusions or the disordered condition of the consciousness, there is even less opportunity for the intrusion of diverting incidents, and both the emotion and the concomitant changes produced by it may be the more purely expressed. It matters not at all that the motion, the fear, rage, hate or whatever it may be, is founded on a false belief. It is presumably real as far as the patient is concerned and stirs him just as deeply as though it had its foundation in actuality. Unfortunately, physical concomitants, of which expression-movements constitute but a small part "stand in no constant relation to the psychical quality of an emotion."[10] We know in a general way that the movements of expression vary with the intensity of the emotion, being active when the latter is of medium intensity and suddenly inhibited when it is violent. An emotion, however, is such a complex psychical compound and capable of so many individual and undeterminable variations, that we can

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scarcely ever hope to formulate a constant parallelism between an affective process and a motor response. Still, the conclusion, that, in psychoses where the affective content is unmistakably virile and continuously being fed by realistic delusions, a large part of the so-called katatonia may be but a logical sequence of the emotional demands, is not entirely lacking in plausibility.

When the apprehensive factor was absent or less important and the depression apparently fixed at the same low level, the katatonic-like phenomena were apt to have a much more limited range and to be characterized by a greater monotony. The stereotopy of speech and movement was invariably the same, and the attitudes assumed seemed to be almost exactly reproduced, day by day, for long periods of time. However, they were all accompanied by the more or less obvious manifestations of depression, such as the troubled facies, bowed head and dejected bearing. It may be that the long continuance of a single emotion on a relatively low plane may weaken it and so simplify its composition that finally it is not much stronger than a mere feeling, and consequently calls for only a narrow range of expression. I do not wish to propose that true katatonia or katatonic-like manifestations, which cannot be distinguished from true katatonia, do not occur in conditions where the emotions are still liable.[11] However, they are certainly much more infrequent and probably not in such close connection with leading emotional trends as they seemed to be in these cases of involutional depression.

The refusal of food, which was present in all but one of this series of cases, was at times directly connected with somatic and somatic-nihilistic ideas, again it was influenced by the delusional fear of poison. Only two patients showed brief, mild stupor, and in no instance was the resistiveness absolute enough to be classed as *negativism,* the one symptom which Kraepelin considers most significant for katatonia.

Dementia Præcox Group.

In the next group there are five cases; two of them are clearly dementia præcox, in two more this diagnosis is the first choice with a slight possibility of manic-depressive, and the fifth is doubtful, but was allied to dementia præcox. In the two cases in which the diagnosis was made positively, the histories as to the date of

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onset are not entirely reliable. The fact that case No. 13, as a young woman was "moody, sensitive, seclusive, and at times almost paranoid," * that case No. 14 has been "morose and unhappy" since her marriage at the age of 25, and finally that the allied case No. 17 was "nervous" for two months at 33, recalls Bleuler's belief that "late katatonia" is merely the recurrence of an early psychosis which had become quiescent.

In the group under consideration, the katatonic symptoms in the first four cases, at least, were of the same type as is met in early katatonia, and they were frequent and prominent enough to bring the question of "late katatonia" into serious consideration. They impress the observer as independent of all environmental contact, unrelated to whatever emotional life remains, purposeless and even contradictory as compared to the delusions and psychotic content in general. Their mechanism is extremely baffling unless we choose to bridge many gaps with the vaguest assumptions. It is suggested that for this very reason, they may be with the more propriety regarded as genuinely katatonic, even though this would in some sense limit katatonia to dementia præcox alone.

As suggestive evidence against "late katatonia" there is the fact that in none of these patients was there any indication of sustained katatonic excitement nor of stupor, and neither was the resistiveness negativistic in type. In case No. 17, the depression was fairly constant. The resistiveness and persistent food refusal were apparently a confused outgrowth of delusional fears that eating or the performance of other acts might in some way endanger her husband and children. "Everything I do is going to hurt them and everything I don't do is going to hurt" is typical

* The following additional history rules out the possibility of "late katatonia" in this case and fixes a much earlier date of onset for the psychosis. "At 25 the patient thought that persons on the streets were making adverse comments or ridiculing her. At 32 she would suddenly go home for periods of three to six months, leaving the responsibility of her house and children, without any thought of their welfare—'they got on her nerves.' At 35 she would lock all her children in the house, excepting the youngest, whom she would take with her to the woods for an entire afternoon. At 38 the patient left her home, taking the 18 months' old baby, and returned in six months with the child dirty and the back of its head flat from lying constantly in its carriage. Without reason she ordered the housekeeper to leave."

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of the mental conflict which was attendant upon even the most common place actions. With the exception of the long-continued abstinence from food, the katatonic symptoms were not especially marked; the mutism was quite temporary and the catalepsy doubtful.

Unclassed Group.

Case No. 18, which was unclassed with a possibility of involutional depression is grouped with cases Nos. 19 and 20, in which the arteriosclerotic factor was considered because in all three a common element of toxicity was particularly prominent. With this exception they probably represent essentially different processes. In the first case confusion was marked and disorientation present, in the second and third the clouded sensorium suggested delirium and in addition there was fever. That katatonic-like reactions may occur in the course of infective-exhaustive states and in conjunction with febrile reactions has long been recognized. Bonhoeffer[12] describes a number of remarkable katatonic syndromes, including negativism under the fever amentias, and he dispairs of a distinction between them and true katatonia on the grounds of the clinical picture alone.

In case No. 21, unclassed, there is a well-founded suspicion of an arteriosclerotic process. Among the initial symptoms were headache, dizziness, twitchings of the arms and body, and staggering while walking. The systolic blood-pressure was 200. To be sure there are no indications of localized cerebral damage, but these may be absent from the early and even moderately far-advanced stages of the disease. The katatonic symptoms were not distinctive and of a type that is apparently fairly common in arteriosclerotic dementia. Here there seems to be a certain resemblance to the effects of excitative brain phenomena in that the katatonic-like outbreaks often recur in attacks or "spells" and are succeeded by comparative calm. They may, however, be striking enough to complicate a doubtful picture and suggest a primary katatonia.

Case No. 22, unclassed, is an interesting example of Urstein's hypochondriacal-nihilistic katatonia. This form he asserts is most common in women of culture and education. The patient was an authoress and the highly fantastic delusional content is undoubtedly influenced by literary ability and the habit of painting vivid

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word pictures. Such ideas as being "but an imitation body without vocal chords nor any orifice to take in food, compelled to exist in a make-believe world, surrounded by manikins and stuffed dolls, denied air to breathe and with scarcely sufficient space to turn about in," were no doubt instrumental in calling out all sorts of behavior abnormalities. The katatonic-like symptoms were most prominently displayed in connection with the freely expressed delusions. The resistiveness never amounted to negativism and there was neither typical excitement nor any trace of stupor.

Case No. 23, is an unsolved problem. The psychosis showed little in the way of determinative emotional trends, although irritability was generally present. A recovery was scarcely anticipated. The paranoid element was indefinite, yet there seemed to be a fairly constant undercurrent of suspicion. The katatonic symptoms when they occurred were apparently clear-cut enough, but their appearance was comparatively rare, their exhibition brief and the major manifestations negativism, excitement and stupor were missing.

Case No. 24, unclassed, is noteworthy for the wealth of katatonic symptoms displayed. This patient was also one of two of the entire series who developed an outspoken stupor which here included resistiveness, mounting to the grade of negativism. The delusions were not well defined. The katatonia was least marked when the apprehensive-depressive factor was prominent and with the apparent waning of the latter it began to assume a dominant rôle. The irritability, however, increased markedly, is now a striking feature of the case, and is more or less closely associated with the katatonic symptoms. Many of these at least from an objective point of view bear considerable resemblance to early katatonia as seen in dementia præcox.*

* The difficulties which confront the clinician when he attempts to pass objective judgment upon the diagnostic value of even apparently out-spoken katatonic symptoms are considered practically insurmountable by Stöcker [28] who seriously questions whether a difference really exists between katatonic stupor or excitement and their respective manic equivalents. Parallel columns from Kraepelin are quoted to prove the essential sameness of the two conditions. Stöcker feels that whatever dissimilarity is present is not explainable on the basis of the symptoms themselves, but rather on the effect of the change wrought by the "psychic characteristic of per-

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The stupor for the first week was quite profound. Sensory stimulation failed to elicit any response, and attempts at passive motion immediately developed an exquisite muscular negativism. On the eighth day the patient began to take food from a spoon. During the second week automatic movements of the head and sometimes of the body appeared, the arc of motion being about 90° and the rate 25 times per minute. Any effort to inhibit these movements at once produced powerful muscular opposition. Since the cessation of the stupor the patient has been extremely irritable, inaccessible, resistive, usually mute, destructive and has violent scolding spells.

Case No. 25, is reported in some detail for three reasons. First, as a clinical problem it possesses more than the usual quota of interesting features. Second, it typifies a group which is unhesitatingly classed "late katatonia" by some observers, but which at least for the present, Kraepelin would retain among the presenile psychoses on the strength of the anatomical picture. He probably has it in mind for the future as the nucleus of a new classification. Third and most important it came to autopsy and the findings will be a valuable contribution to the pathology of unclassed mental diseases, particularly those which are katatonic in type and appear after the fourth decade. Extending over a period of 29 months, the psychosis simulated at various times, three distinct conditions, namely, involution or pre-senile depression, paresis and finally an undetermined katatonic process.

Case Report.

Case No. 25. Admitted 4-12-1915, at the age of 51.

Family History.—The family stock is apparently sound, the histories of the grandparents and parents being free from any taint of mental disease or neuropathic tendencies. The father lived to be 80 and the mother is

sonality" which is the essence of each disease. In manic-depressive insanity the psyche of the patient is usually more or less conformable to that of the observer, therefore the connection and sequence between thought and act is reasonably patent. In dementia præcox, however, there is a psyche consisting largely of intrapsychic ataxia and blunting of emotional lability, which is totally at variance with that of the observer, who is therefore unable to place himself *en rapport* with the patient and for this reason regards his acts as disconnected and purposeless. If allowance be made for the "Grundpersonlichkeit" there is in katatonic stupor a retardation of the same set of psychic elements as in depressive stupor and in katatonic and manic excitement a similar hyperactivity.

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clear and bright at 83. In the collateral branch there is one sister in the terminal stage of dementia præcox, and a brother who has disappeared. The four remaining, two brothers and two sisters, are normal and capable men and women.

Personal History.—The patient was fifth in the birth order, and was a bright baby, speaking and walking earlier than the other children. She had a social, practical and rather positive personality, and her judgment was valued by the other members of the family. Never married and voluntarily assumed the care of an invalid mother. At the age of 40 there was a brief mental disturbance lasting six weeks and ending in recovery. The history of this episode is very indefinite. Apparently it was precipitated by overwork, was abrupt in onset and manic-like symptoms predominated. After restoration to normality she again took up the thread of her former life. The psychosis had left her character-traits unchanged and she was as capable and efficient as ever until the onset of her final illness.

Present Illness.—In September, 1914, she rather suddenly became apprehensive and developed ideas of reference. She felt that some great calamity was to overtake the family and "that everything was to be lost." The posts on the street were figures which were watching the house. There was something which she could never name nor definitely describe, but it controlled, watched and worried her. This thing was often threatening and filled her with fear. Sometimes it said it was going to take everything the family had; once it told her to jump out of the window and she tried to do so. The affect in general corresponded to a state of agitated depression. On admission in April, 1915, the patient was clear and oriented, but more or less restless, uncommunicative and suspicious.

Physical Examination.—Rather poorly developed, with wasted musculature. Over the apices of the lungs the percussion note was dull and the breathing shallow. There was a moderate degree of arteriosclerosis, the systolic pressure was 145 and the diastolic 100. The right pupil was irregular in outline and reacted sluggishly to light. Fine tremors of the lips, facial muscles and the eye-lids. The urine showed a moderate amount of albumen. Serum Wassermann weakly positive, and the spinal fluid negative in the amount of 0.2 c. c. Menstruation had definitely ceased six months before the onset of the psychosis.

For five days following admission the patient maintained a non-committal attitude and succeeded in concealing her real state of mind. On the fifth day there was an abrupt transition to a condition of agitated apprehension, with self-accusation and considerable confusion. On the seventh day there was a period of brief but intense excitement, during which she attempted to kick and bite her nurse. This was undoubtedly a reaction to auditory hallucinations. She began to tell of a machine, "a sort of collector of thoughts which speaks to people." During the second and third weeks there was almost constant depression, agitation and apprehension. The patient was now no longer oriented, her confusion increased markedly from day to day and often she was inarticulate and mute. There were periods of violence again evidently dictated by vivid hallucinations. Food was

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frequently refused and nasal feeding had to be employed. During the next two months a series of grandiose delusions developed. "Our estates are gorgeous." "My income is billions and billions." "I have banks in England and America." "I had invitations from ever so many people, from kings and queens to be queen." "I am queen of the world" are typical examples of her daily productions. Running through the fabric of such extravagant fancies there was still the thread of apprehensive-depression, which at times mounted to a veritable frenzy of fear. "Why man I have been through murders and murders. They took me around to all those murderers. They came and injected all that poison into me. Don't put that stuff down. Oh God! Oh God!" Again, "Don't you remember when they put me in that basket of boiling water?" These outbursts were usually accompanied by moaning, sobbing and wringing of hands. At times her utterances were hopelessly disconnected and frequently she was unable to put her thoughts into articulate language. Once when shown a pencil and asked to name it, a full minute elapsed before she was able to pronounce the word. She could repeat all the letters of the alphabet after the examiner. There was still deep confusion and constant restlessness, and in spite of frequent tube-feeding the weight declined. During the months of July and August, 1915, 21 months after the onset of the psychosis, the patient showed considerable improvement. She oriented herself, developed an interest in simple occupations and read a book of which she was able to give a fair account from memory. In September the consciousness again clouded and the orientation was lost. In October she made two attempts to strangle herself, once by tying a piece of ribbon and again a strip of linen around her neck. The restlessness, agitation and resistiveness reappeared and daily became more intense. In November and December there were two more serious suicidal attempts. Speech became constantly more difficult and at most consisted of a few scattered words or disconnected phrases. The patient was now practically negative. She assumed fixed attitudes and the head would be so firmly pressed against the chest that it was impossible to raise it. On the first of January, 1916, stupor developed, which lasted until her death on the 22d of March.

The resistiveness, impulsive violence and much of the destructiveness and food refusal made their appearance in close connection with hallucinatory paroxysms of remarkable vividness, in which the consciousness was deeply clouded. During the two months, marked by improvement, reorientation and clearing of the sensorium, they were scarcely in evidence. The fixation of attitude, which partook of true negativism, was most prominent just preceding the onset of the stupor. The stupor was profound, but at times strong stimuli elicited a response. The eye-lids fluttered in reaction to pin-pricks, the face flushed, the veins stood out on the forehead, tears started from the eyes and there was frequently a swallowing sound following passage of the feeding tube. Although there was never any suggestion of catalepsy, yet the muscular opposition was not always equally intense and often it was absent altogether. The urine was only infrequently retained. The patient occasionally changed position; put a finger to the nostrils and

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opened her eyes. On the somatic side were the generally sub-normal temperature, with now and then an ephemeral elevation, the weak pulse, the slow and shallow breathing, a few vomiting spells, vaginal discharge, practically negative urinary findings and a progressive decline in weight from 92 to 58 pounds. The possibility of an undiscovered toxic process cannot be eliminated. In the absence of definite and clear-cut katatonic manifestations, and on account of the doubtful character of the stupor, "late katatonia" must be viewed with considerable uncertainty. However, this is distinctly one of those cases which "anatomy must decide" and the gross and histological findings will be most important in this connection.*

RÉSUMÉ.

The analysis of the psychosis appearing during and after the fifth decade discovers a fairly large percentage (25 of 117) in which on the grounds of a narrower symptomatology there is the apparent probability of a katatonic process. When subjected to closer scrutiny and contrasted with the entire clinical history and course, this probability dwindles to a doubtful possibility. It may be reasonably objected that since there is no real criterion, by which to measure katatonia, it cannot be decided on clinical evidence alone that certain questionable manifestations may not be truly katatonic after all. It is, of course, realized that such a decision is often impossible, but observation on early katatonia has formulated fairly definite characteristics for it and these are widely at variance with those of the usual so-called "late katatonia." Outspoken negativism, recurring excitement and stupor, and possibly mannerisms without which one would hesitate to diagnose katatonia during the second and third decades, were in the late psychoses usually conspicuous by their absence. The "negativism" was practically always resistiveness called out by environmental, affective and delusional factors; the "excitement" was not sustained and was generally not totally divorced from the surroundings, even when the orientation was defective and the consciousness clouded. The stupor, excepting possibly in one patient, was not typical for katatonia. The reaction to stimuli gave the impression that a marked retardation had been partially overcome with great difficulty and never was there a sign of the lightning-like movements, sometimes as quickly inhibited or reversed with which the true katatonic commonly breaks through the stupor.

* To be reported by Dr. Samuel T. Orton.

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Of the psychoses brought into question, there were a few clear-cut cases of manic-depressive insanity, in which the "katatonia" was purely environmental and was largely a behavior response to the persecutory delusions of patients in whom irritability was often the most pronounced element of affect-life. The major proportion (9 of 25) comprised the involutional-depression group. When the ruling emotions were intense the possibility of explaining certain of the katatonic-like symptoms (resistiveness, violence, screaming spells, fixed and peculiar attitudes) on the basis of "phylogenetic associations" was considered, and it seemed more natural here than in psychoses whose very essence precludes the play of strong emotions. When the affect was less sharply defined, the katatonic-like phenomena had a more monotonous and restricted character, and seemed less purposeful, yet a connection with the emotional factor was never entirely wanting. It may be pointed out that in the course of years, affect-like in a certain percentage of this group may become blunted and perhaps gradually fade out entirely to be replaced by an end state more or less suggestive of katatonic deterioration and that the evaluation of the katatonic symptoms should wait upon the final outcome. On the other hand, symptoms which are to be distinctive and diagnostic should also show these traits at the height of the psychosis when later complicating factors are less likely to confuse the observer. If their consideration is too long postponed, there is the danger of clothing them with an importance they did not possess, simply because the terminal status, which may in reality be the product of many added conditions, seems to be in a general sense indicative of their early prominence. One would expect to find in those rare cases of katatonic dementia præcox developing after the age of 40, the ear-marks of essentially distinctive katatonia. While the syndromes as a whole did constitute a fairly strong plea for "late katatonia," yet one cannot well help questioning why more determinative signs, such as true negativism and stupor did not appear. Again in one of the patients the revised date of onset because of additional history, indicates an earlier process, and in another the anamuesis is decidedly suspicious. It is particularly in the katatonic form of dementia præcox in which long remissions are found and for which also a fairly high recovery(?) rate is recorded. Retrospective investi-

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gations of "late katatonia" should therefore take into account an appreciable margin of error arising from the fact that after many years the account of the early life is frequently unobtainable or unreliable and suspicious episodes may escape attention. Practically all of the cases, which fall outside of the manic-depressive or dementia præcox classification may be for convenience rather loosely grouped under the pre-senile insanities. Here, as at any life-epoch, the possibility of a katatonic-like reaction to infective-exhaustive and febrile states had to be at least borne in mind. Undoubtedly arteriosclerosis was also operative. Measured by strict clinical rule the majority of such symptoms departed from the usually accepted standards for katatonia, but often considerable doubt remained even after rigid inquiry. Before such cases are unhesitatingly placed in a classification, which is naturally and overwhelmingly associated with adolescence rather than with pre-senium, the pathologist must make a comparison test with early katatonia. As his opportunities for investigation are increased, he may be expected to link true clinical katatonia with more definite anatomical and histological findings. Thus far the work of Nissl and Alzheimer on "late katatonia" has not discovered any relation with the earlier process.

The Infrequency of "Late Katatonia."

The infrequency with which "late katatonia" is reported, at least suggests that its diagnosis rests on an insecure foundation. Petrén found 24 cases beyond the age of 40; Shröder, 16 (earlier attacks in 4) and Zweig only 5. Contrasted with these figures are Urstein's remarkable statistics based on 3500 cases—2.5 per cent for men and 9¼ *per cent for women.*

"Late Katatonia," Manic-Depressive Insanity and Arteriosclerotic Dementia.

The late involution and pre-senile insanities, which furnish the largest quota of cases likely to be regarded as "late katatonia," occur during a life-epoch, when the mixed forms of manic-depressive insanity and arteriosclerotic dementia are apt to be intimately associated. The possibility of the co-existence of these two diseases rests on a fairly sound basis in that the pre-senile epoch

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favors the occurrence of degenerative vascular changes, that manic-depressive insanity probably carries within itself certain predisposing factors (frequent oscillations in the blood-pressure and in the innervation of the vessels) which tend to lower the resistance of the circulatory apparatus, that the prognosis for manic-depressive insanity, which is overwhelmingly good during early and middle life, becomes quite uncertain just prior to the arteriosclerotic age, thus indicating the intrusion of a new and unfavorable complicating element, and finally that it is sometimes possible to isolate the features of each disease from the whole picture. For instance, an intrinsically unimpaired affective reaction may be present for years, gradually it declines and shows the obvious marks of emotional blunting, at last it is blotted out altogether and the unmistakable evidences of dementia appear, perhaps to be accompanied or succeeded by the focal effects of localized brain damage. Often too, however, certain manic symptoms, remnants of distractibility and flight, or depressive manifestations, melancholic delusions, may persist into almost the very terminal stages of the disease, to be exhibited along with advanced memory failure and the physical signs of gross brain lesions.

The disappearance of emotional life seems to be most gradual and insidious in those cases of manic-depressive insanity in which the depression has been maintained on a relatively low plane for a long time, and where the speech and movements of the patients are peculiarly narrow and restricted in type. The association between the affect and its expression in word and gesture, which was once fairly clear, now becomes more and more indefinite and with the loss of the former, the latter may be apparently perpetuated in a purely automatic manner. The connecting link has been broken and that which was once a somewhat monotonous reaction to a low-grade but definite emotional state, has become a purposeless and stereotyped formula of sound and act. If, at the same time, the dementing process, presumably arteriosclerosis, becomes more distinct, it may bring in its train a new group of katatonic-like symptoms, such as violent outbreaks with scratching, kicking, biting, screaming and destructiveness. Such manifestations are usually abrupt in onset and termination, often recur, are frequently accompanied by confusion, and in general resemble the expression of irritative phenomena. We may have then a number of katatonic-

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like characteristics, which are apparently compounded of the remains of a former depression and an additional set of symptoms due to an added factor, possibly arteriosclerosis. This terminal stage is very apt to be misleading and to prompt the diagnosis of "late katatonia." However, one would hesitate to select from a group of dementia præcox patients in the final period of the disease, those cases which were once hebephrenic, katatonic or even paranoid. Here the dementia has reduced a number of once separate and individual groups to a more or less common level, from which all traces of former distinctive attributes have been eradicated. This is in a sense true of all deteriorating psychoses. The more advanced their course, the more blurred become their outlines and the more closely they resemble each other. An attempt to read back into the early history of any psychosis, from the scattered and distorted fragments remaining after the lapse of many years, is very likely to prove futile. If the "katatonia" observed in many of the pre-senile insanities is actually katatonia, then at least it represents a process which differs essentially from the katatonia of early life, such as is for instance most commonly encountered in dementia præcox. Here we have a symptom-complex, which is clear-cut enough to plainly signal out a number of cases from a larger and more general grouping; in the presenium we are generally dealing with an undeterminate set of isolated symptoms, which play only a subsidiary part, at least until the deterioration is well established. It is quite possible that a number of the "late katatonias" are merely manic-depressive psychoses unfavorably influenced and changed by arteriosclerotic dementia, and that the katatonic-like symptoms displayed are only an incidental end result and have little in common with the essence of either condition. The fact that focal symptoms are not always present is not of great significance, for it is recognized that in a large proportion of arteriosclerotic mental disease, such features may be absent for many years. Urstein admits that a certain percentage of his late katatonics suffered from paralytic seizures and gave other evidence of gross brain involvement. It must also be borne in mind that the difficulties which may stand in the way of the clinical recognition of an arteriosclerotic psychosis are commonly underestimated. The condition of the peripheral arterial system and the blood-pressure are far from being infallible

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criteria. Advanced sclerosis of the surface vessels may, of course, co-exist with unimpaired mental capacity, and Romberg states that in only 10 per cent of arteriosclerotic insanity is the blood-pressure elevated.

"Late Katatonia" and Dementia Præcox.

Although the extreme view that katatonia can occur only in conjunction with dementia præcox is no longer entirely tenable, yet it cannot be denied that it is only in this disease in which it is both common and distinctive in type. In spite of the frequency with which it is reported in other conditions, we must go back to dementia præcox if we wish to study it in its fundamental expression. Its essential features, namely, disassociation, absence of affective-reaction and peculiar detachment from the environment are here consistent with and not in contrast to the whole psychosis. When pure katatonia occurs in what is otherwise an "emotional" psychosis, it is perhaps well to postpone judgment for a time at least. Of four cases in early life, which showed well-developed katatonic episodes, but in which the manic-depressive coloring, plus a favorable outcome, inclined us to the more hopeful view, two have relapsed, one with probable and the other with positive dementia præcox symptoms. There is undoubtedly a sound reason for Kraepelin's unwillingness to accept unreservedly the katatonia which is encountered outside the schizophrenic group. The association between the symptom katatonia and the disease dementia præcox is so close and their nature so similar, that when we discover signs of the former in any psychosis, either organic or functional, we naturally subject it immediately to the clinical criterion of the latter, in order to see just how far it departs from the commonly accepted standard. If the katatonic evidence is clear-cut, prominent and long-continued, we would probably be willing to rule out entirely the possibility of the schizophrenic process.

There is little in the way of convincing argument to prove that dementia præcox may occur at that period in life when "late katatonia" is brought into question. In spite of the repeated liberal extensions of its boundaries, dementia præcox, with the exception of the paranoid forms, still remains peculiarly a disease of comparatively early life. The assertion that certain indefinite psychoses of the late climacteric or pre-senium are in reality

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dementia præcox, disguised by the influence of the unusual life-epoch, is not well supported by the facts. It is usually the deterioration in these conditions, which is cited as main proof of their relationship to the dementia præcox group, but here the dementia is either accompanied by psychical and physical manifestations, which point to an organic origin, or else it is merely the final stage of a disease, which during its developmental period and active course presented an affect strong enough to set aside the possibility of dementia præcox. It is a negative point of some value, that those katatonic-like symptoms, which for many other reasons must be classified as doubtful, make their appearance principally at a period when katatonic dementia præcox must be regarded as something of a curiosity.

The Modifying Effect of Certain Incidental Mental and Physical Factors.

There is probably no epoch, especially in the life of woman, during which the development and content of mental disease is more markedly influenced by various inherent and extraneous factors, than the climacteric and pre-senium. These two periods are not often satisfactorily separable, they merge gradually one into the other, and the principal objective sign of the menopause, namely, cessation of the menstrual flow, is after all only a very unsatisfactory and variable criterion of the progress of internal and probably much more important processes, while the pre-senium is practically independent of actual age in years. The psychoses which arise during the fifth and sixth decades are extremely hard to interpret and present a most diverse symptomatology and this is undoubtedly due to the fact that apparently they are often as much the expression of certain mental and physical changes peculiar to these decades, than of distinct disease entities. Neither the frequency nor unusual character of these insanities need seem remarkable, if we recall that they appear at a time when important chemical and psychic alterations attendant upon the extinguishing of the sexual function and beginning regressive somatic processes all stand in close proximity. Further there is added even in normal women, the mental conflict springing from the necessity of attempting to make an adaptation to meet the demands of a new and often far from promising future. It is not at all strange,

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that especially where an hereditary weakness already exists, such adaptation may fall far short of accomplishment and a long and severe attack of mental disease be the final outcome of the struggle. Are any of the symptoms displayed in the late psychoses, and particularly are any of the katatonic symptoms to be regarded as merely a pathological distortion of the characteristics, which practically every woman shows in greater or lesser degree during the climacteric and pre-senile years?

Personality and Character-Traits.

Probably the personality is completed long before the fiftieth year has been attained. The formative period is over, the psyche is in a condition which is unfavorable for the reception of new influences and the character-traits, which have been shaped and moulded by the experiences of youth and middle life, may be expected to endure in their final form, even in the presence of mental disease, provided of course that such disease is not of a disorganizing and deteriorating type. Indeed, certain dominant trends often seem to be magnified and to stand out more prominently. We occasionally find patients who have perhaps inherited rather positive, strong-willed tendencies, which were displayed quite early in life, strengthened and increased, although of necessity in a measure controlled as later associations provided more points of contact with the environment and markedly emphasized during the climacteric years, in whom the katatonic-like phenomena bear the stamp of pure obstinacy. The resistiveness, the mutism, and at times the food refusal and destructiveness sometimes strikingly resemble an exhibition of bad temper on the part of a stubborn child. One of my patients, for instance, frequently declines to take the nourishment which has been ordered. Following the emphatic insistence of the physician or nurse, for whose authority she has a certain degree of respect, she will often finally yield, seize the glass, drain its contents in one gulp, then either set it back with great force on the table, or hurl it into a corner of the room, and conclude the performance by grasping the chair and thumping it so vigorously and repeatedly against the floor, that the arm pieces and rockers have several times been broken. All such episodes are accompanied by unmistakable irritability and anger, which is clearly expressed in the countenance and general

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attitude of the patient. At times, the physician is able to cut short the outbreak by sternly insisting on better behavior. Somewhat similar features, although much less clear, were present in a few other cases of the series. Such manifestations differed from the katatonia of early life as exemplified by dementia præcox. They were in close contact and in fact apparently provoked by contact with the surroundings, were accompanied by considerable emotional display and stood out as completed, purposeful acts, as contrasted to the non-environmental, affectless, disassociated and purposeless movements of the true katatonic præcox patient. Their mechanism may perhaps be sought in the persistence of an inflexible and obstinate make-up, which in normal life was held at least partially in check, but which during the psychosis is given full sweep because every need for inhibition has been removed.

Investigation has shown that certain disturbances of affect-life and various peculiarities of conduct [14] may be as common as the numerous somatic symptoms, which accompany the establishment of the menopause and like them are to be regarded as practically physiological for that time of life. Of course, they are usually extremely mild and fleeting in the normal woman, yet they may be quite prominent and fairly long-continued in individual instances, which one would hesitate to class as pathological. Among the more usual manifestations, which make their appearance, even during the physiological climacteric, are feelings of jealousy, abrupt emotional oscillations, light depressive states, impulsive behavior and often quite *pronounced irritability*. The prototypes of these conditions may perhaps be found in the strong delusions of jealousy, the deep depressive coloring and the frequent outbreaks of angry irritability, which are encountered in some of the late psychoses. In five of my patients the latter reaction was strikingly evident, and in them the inaccessibility was marked. Attempts to overcome this *noli me tangere* attitude would call out protracted scolding spells, aggressiveness, and even actual violence. Of course, delusions probably also played a part in the productions of these katatonic-like episodes, but one felt that the irritability was the more constant and underlying factor, and that even indifferent stimuli were sufficient to set into motion a characteristic vocal and motor response.

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The Affect.

Perhaps the most usual emotional accompaniment of the late functional psychoses is a prolonged and often rather monotonous depression. Probably both its variety and character are in a measure determined by the period during which it occurs. The affect-life has, in a measure, exhausted itself by the frequently repeated and more intense demands of earlier experiences, further it has no doubt been influenced by the decline of physical and mental vitality, which begins at the menopause and unless stimulated by vivid delusional formation, it is very apt not to rise beyond a rather low level. As has already been mentioned, its expression in speech and movement partakes of the monotony and restriction of the emotion which gave it birth, and therefore often gives the impression of katatonic stereotopy, particularly if after many years the last remnants of the former are replaced by psychic deterioration, most likely of organic origin.

The State of the Consciousness.

The general condition of the consciousness and the element of confusion is of interest in its possible relationship to the late katatonic symptoms. When it appears in conjunction with the climacteric and beginning physical regression of the pre-senium, it is at least suggestive of an imperfectly balanced metabolism, with consequent toxicity from the accumulation of katabolic products. Excluding those cases well beyond the years of menopause, four of my patients showed marked confusion, and in four more clouding was present, although much less evident. The resistiveness, impulsivity, and at times the destructiveness simulated a kind of uncertain struggle against an oppressive and possibly threatening environment. It was neither the purposeless and seemingly independent excitement of the dementia præcox patient, nor did it amount to the extreme degree of psychomotor activity seen in the deliria. Again, as in the katatonia of dementia præcox, the peculiar and complete severing of external relations was not present. There, although the patient frequently reveals by a chance word that the consciousness and orientation are retained, yet he is clearly living and moving in a detached sphere, whose revolution is apart from and has nothing in common with the world of other people. Here, in the late disturbances, although

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the orientation is often totally lost and the sensorium deeply clouded, the patients are still closely bound to real, though misinterpreted, surroundings. Their productions prove that the remarks of fellow patients, the passing to and fro of nurses and others, the sights, sounds and daily happenings on the ward, are all fraught with meaning and not uncommonly are woven into the psychosis, coming to expression in a distorted and fragmentary manner. In the case reported in detail, the katatonic-like phenomena were in especially close connection with the confused-hallucinatory periods, contact with the environment was probably never entirely broken, and even during the stupor, strong stimuli elicited at least a partial response.

The Delusions.

The type of delusions which occur also bespeak the influence of a life-period, during which the whole economy is deeply stirred by an important and far-reaching process (climacteric) and toward whose close begins the physiological decline. In the presence of numerous sensations and disorders, referable to the genital, circulatory, nervous and digestive systems, it is not unnatural that the attention should be sharply focused on the body. Hypochondriacal and somatic delusions are more common than somato-nihilistic. However, when nihilism is present it often involves the stomach and intestines and may dictate the refusal of nourishment. In the cases studied it was apparently a more or less logical deduction from false premises and was generally consistently and strongly maintained. It did not resemble the contradictory abstinence of the katatonic of early life, who may refuse food at one meal and then devour double or triple quantity at the next, or disregard what is placed before him only to pilfer his neighbor's supply.

Sex.

The infrequency of reported "late katatonia" in the male sex is rather astonishing. Shröder found only 3 in a series of 16, and Urstein places it as four times as common among women. No such disparity exists in early katatonia. Its postponed development must be either favored by some unknown sexual factor in later life, or else and what seems more probable, it is only more or

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less closely simulated by the far more important and peculiar influence of the climacteric-pre-senile epoch on the body and psyche of woman, and on the expression and content of the late developing psychosis of other types.

KATATONIA, A DISEASE OR SYMPTOM-COMPLEX.

That a katatonic symptom-complex may occur in the greatest variety of conditions has long been recognized. It has been described by numerous observers * in toxic and exhaustive states, typhoid and other acute infections, as a post-operative sequel, in renal insufficiency, organic brain disease, abscess and tumor, cerebellar hemi-atrophy, head injuries, general paralysis, epilepsy, hysteria, manic-depressive, and other so-called functional psychoses. Probably its rather striking characteristics, when it does appear, have led to frequent attempts to gather all its manifestations together under one heading and to elevate them to the dignity of a distinct disease-entity. It must be remembered too, that Kahlbaum advanced this view in his original description. Later, Spitzka, Hecker, Meynert, Hammond, Neuendorff, Neisser, Fink and Brosius all wrote of it as a separate form of insanity and more recently Urstein assigns to it a broadly inclusive and very important rôle. The very fact that it is so widely distributed should create some doubt as to its significance as a primary process. Again, it may be very mild and transient in one case and dominant in another, a clear-cut, early appearing and long-enduring symptom in one condition and a doubtful and late one in another, and in one patient have a mechanism more or less naturally explainable on the basis of the remainder of the psychotic content, and yet be totally inexplicable in another. To believe that stupor, catalepsy, stereotopy, mannerisms, mutism, and indeed the whole list of katatonic symptoms, must always be produced by the same combination of circumstances and have a similar meaning, would seem as unreasonable as to assert, for instance, that convulsions, coma, cough, or anorexia from the province of internal medicine are always called out by the same basic factors and always have a uniform pathology. Even in dementia præcox considered as a whole,

* Steinheil, Bonhoeffer, Bernheim, Régis et Lalanne, Köttgen, Schmidt, Schäfer, Anton, v. Muralt, Séglas, Näcke, Ideler, Kirby, Taft.

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although each of its forms, including the paranoid is apt to show some katatonic admixture, there is scarcely sufficient clinical evidence to warrant us in revising the usual opinion that dementia præcox is the disease and katatonia the symptom. At most katatonia may be granted a distinctive but still sub-sidiary rôle and be regarded as bearing a somewhat similar relation to the parent condition, as do the sub-divisions of typhoid fever or pneumonia to the original diseases of which they are but the clinical and anatomical derivatives. Especially in the late psychoses is it important to keep in mind the symptomatic value of the katatonic signs and not to bring them into the foreground at the expense of other portions of the picture. In the first place, we are dealing with a period in which katatonia is exceedingly rare, and further if we study the entire life histories of the conditions in which it arises and separate out the symptom groups presented, we are likely to find that the "katatonia" will be somewhat dwarfed by other considerations, such as the affective reaction, the state of the consciousness, perhaps as a measure of toxicity, the delusional content and the general effect of destructive organic brain changes.

Conclusions.

1. The clinical evidence of true katatonia in the late psychoses is neither prominent nor distinctive enough to justify the assumption of a late katatonic disease process and during the climacteric-pre-senile period it is rarely more than a symptom-complex of doubtful diagnostic value.

2. In mental disease occurring during and after the fifth decade, with the possible exception of outspoken dementia præcox, the katatonic manifestations are essentially unlike those of early katatonia and the generally superficial resemblance is often explainable on the basis of certain incidental factors.

3. Among the factors which may be operative in giving a katatonic coloring to the insanities of the climacteric-pre-senile epoch, and which are in some sense peculiar to this period, may be mentioned the relative inelasticity of affect-life, with a tendency to the development of a monotonous depressive phase, the inclination to marked irritability, which may be a pathological increase of the rather common and almost physiological reaction of the menopause, the confusion and disordered condition of the conscious-

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ness, which is probably connected with toxicity due to epochal metabolic disturbances, the influence of somatic and nihilistic delusions, possibly related to similar physical alterations, and finally the effect of regressive circulatory changes which may complicate and alter the expression of the late so-called functional psychoses.

4. "Late katatonia" which is true to type may possibly appear in late dementia præcox, but usually even here it cannot be clearly established clinically, and further katatonic dementia præcox, with an onset after the fourth decade, is extremely rare and practically always open to the suspicion of being a relapse from an earlier psychosis, which had become quiescent.

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A STUDY OF CASES OF MANIC-DEPRESSIVE PSYCHOSIS ARISING AFTER THE AGE OF FORTY.

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From a morbidity standpoint we have come to look upon the period of life which begins with the 40th year and continues for a decade or longer as a more or less important one, not only by reason of its being the time when, in the general field of medicine, malignant disease has to be reckoned with, but in the mental field as well, we find, not infrequently, that psychoses arising at this time seem to have a definite tinge of chronicity. This tendency to chronicity is held by some to apply especially to the manic-depressive psychosis, a psychosis whose characteristic is recoverability from attacks occurring in the earlier periods of life.

What the actual factors are which thus modify the course and outcome of the disease seem to be little known, although a multitude of hypotheses have been offered, the principal one being, of course, the involution. Without going over the ground previously covered by the involution psychosis question, it might be permissible to call attention to the wide disparity of opinion as to what constitutes the involution and what influence, if any, it may have upon psychoses occurring during that period. This disparity of opinion is so wide as to extend from an absolute denial of its existence to the opposite extreme of being the sole etiological factor, so far as the psychosis is concerned. As recently as last year an article appeared in one of the prominent journals to the effect that the term involution adds nothing to our understanding of the disease melancholia; that "the term involutional melancholia is purely one of convenience, having no descriptive, pathological or differential standpoint." Furthermore, we have seen how Kraepelin, through Dreyfus's classic investigation, has narrowed the incidence of involutional melancholia to the vanishing point; yet, in spite of having discarded this entity, many are wont to employ the term involution, allowing the use of it as such to be

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influential in formulating judgments, especially when matters of prognosis are under consideration. Again there appear to be some individuals who, unable to accept Dreyfus's conclusions *in toto,* maintain there may be a small group of cases which, perhaps, are peculiar to the involution. There are still others who not only recognize an involution psychosis, but also profess to distinguish several symptomatic types, all having a different course and outcome.

Not only is the concept of what constitutes the involution poorly formulated, but with almost equal obscurity are the terms " menopause " and " climacteric " applied in a loose way to that time of life when it is assumed that there are organic upheavals in the circulation, ductless glands and what not; a supposition merely, since no one has as yet pointed out or pretends to know what those changes are. When it was found by statistical methods that women were more often affected at this period of life than men, it was natural that the changes resulting from the devolution of the sexual organs should be coupled up etiologically with the psychosis, and for some this unverified explanation remained sufficient. In this connection it seems remarkable that so little attention has been paid to the question whether in women at the menopause the first or recurrent mental attack is modified by it in any particular degree. The present study may throw some, though feeble, light on the matter. Somewhat later the term menopause was broadened to include those men who developed more or less characteristic depressions styled the involution type. Two notable articles, entitled " The Male Climacteric," appeared in 1910, one by Mendel, the other by Church. They characterize this period of life for men as one " in which there is a well-defined tendency to mental instability in the nature of major and minor neurotic disturbances, generally expressions showing an anxious tone of mental feeling attended with more or less depression. Those who have had earlier mental attacks are predisposed to have a recurrence at this period. On the physical side there is loss of weight and an increase of blood-pressure amounting to more than can be attributed solely to the age and general physical condition of the patient. As improvement sets in, the arterial tension subsides to some degree. The gastrointestinal activities being reduced, there are a variety of neurasthenic com-

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plaints, headaches, oppressed feelings in the chest, sudden apprehensions, vertigo, etc." In conclusion, Church finds, that, "after running a variable course, ... the patients regain a fair degree of their former mental and physical characteristics and go on comfortably, with naturally some reduction of their mental capacities." In this description of the clinical manifestations of the male climacteric one can see many points characteristic of the manic-depressive depression, and the question arises whether much of the symptomatology which is attributed to the involution may not in reality arise from a manic-depressive basis. Not all women and certainly not all men are disturbed in this way during the course of the physiological devolution.

We find a similar vagueness with respect to the etiological factors which underlie the manic-depressive attacks occurring at this period. Here again the literature is full of hypotheses, but as yet the practical application of them does not seem to justify the drawing of conclusions as to the rôle played by any group of factors. The great alterations in bodily weight suggested to Kraepelin the presence of metabolic disturbances, but he adds significantly, that on this subject there is not much knowledge which can be used. Moreover, Folin, in his studies at the McLean Hospital, where the diet was accurately determined, concludes: "While variations from the standard are frequent, it is not possible to identify any one metabolism peculiarity with any particular form of mental disease." Since no pathological lesions are found, it is inferred by some that psychical factors are the more influential in the etiology. Those who see through psychogenetic glasses alone tell us that men, as well as women, are apt to merge into an anxiety neurosis at the time when their potency diminishes. Finally some biochemists, working in the field of the glands of internal secretion, have compared the symptoms met with in the psychoses of the involution and those characteristic of juvenile dementia, notably Lomer, who concludes that involution processes and the deterioration processes of earlier life depend on the same causes, namely, pathological alterations of the secretions of the sexual organs.

Among other factors serving to complicate the involution psychosis problem is that of arteriosclerosis. If its presence is so slight as to be almost negligible, we find there is a tendency to pick out certain cases from the involution group and set them apart

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in the so-called pre-senile. From this it is but a step to the senile, with no sharp delimitations anywhere. Without going into details of the discussion as to the rôle which arteriosclerosis plays in the involution psychosis, it may be said that both Kraepelin and Dreyfus caution against inferring the presence of dementia from appearances alone in those cases which have continued many years. The psychotic disease *per se* is not responsible for whatever dementia may be present, but that it arises from some intercurrent complication, and this is often arteriosclerosis. In the late manic-depressive attacks it is frequently an accompanying factor; if not already present, the ground plan for its development, in the depressed states especially, is laid in the worry and anxiety, both recognized contributing causes of the disease. We find, however, that there is a tendency to assume that certain symptoms are the result of arteriosclerosis, when the existence of such is more or less conjectural. By and large it seems to be the consensus of opinion that one is not justified in establishing the presence of cerebral arteriosclerosis from the pressure of systemic arteriosclerosis alone. This was clearly demonstrated by Mitchell and Southard, who found in a series of 23 autopsies, among which were 11 manic-depressions clinically, that there was no regularity nor relation between the arteriosclerotic invasion of the systemic and cerebral vessels. The analysis further suggested that even in the presence of cerebral arteriosclerosis without gross brain lesion, the relation between it and the mental symptoms is not as close as is often assumed. It would appear that the only safe criterion would be the evidence presented by the neurological findings.

Although the fundamental factors which are involved in the involution problem are more or less obscure and poorly formulated, there are, nevertheless, certain points with reference to the manic-depressive psychosis whose attacks occur at the involution period which seem to have become established through observation and experience. Numerous investigations of the subject which have been made, although differing in detail, are in the main quite uniform in their general conclusions. Thus Hösslin, who reviewed 288 cases, found that the late occurring attacks tended to become chronic, and, although they did not terminate in dementia, often showed a mental defect in the form of emotional debility. He feels that the prognosis for cases with first attack after 40

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should be guarded. Gaupp analyzed 300 cases, of which 51 were manic, the remainder depressions. The manic phase occurred more frequently with men. The course varied from single to circular attacks, the latter having a tendency to continue into advanced life. Those cases showing retardation and inadequacy as the principal symptoms recovered; while those showing anxiety, hypochondriasis, volubility, etc., tended to persist until deterioration set in. Fauser, in addition, found that certain depressions occurring in early life had practically the same features as those occurring at the climacteric period. Stelzner, in 200 cases, found 18 of climacteric melancholia, all of which recovered. In Dreyfus's series also, all the cases with first and single attack at the involution period recovered. Dreyfus further concludes that there is no special relation between age and the duration of attack. Single depressions are more frequent with no corresponding manic phases. The attacks are of longer duration and there is some difference in the character of the delusions. Sixty-six per cent recovered, 8 per cent demented (the result of arteriosclerosis), 25 per cent died unrecovered. Kraepelin, in accepting Dreyfus's conclusions that involution melancholia as an entity does not exist, adds that the peculiarity of the late occurring attacks consists in the fact that they develop in advanced life and have a somewhat different clinical picture.

In accordance then with the views commonly held, in cases of manic-depressive psychosis with late onset, depressions predominate, women are more often affected, the duration of the attack is longer, a different symptom complex develops, characterized by anxiety states, feelings of unreality, and, in the presence of mental clearness, absurd delusions, often of a somatic nature, are expressed without adequate effect.

Having these characteristics in view, an analysis of 150 cases of manic-depressive psychosis with first attack at or after the age of 40 has been made and comparisons drawn. In order not to burden the communication with the details of case histories and statistics, the summaries are given only. In accord with other studies it was found that depressions predominated, although there were 22 manic cases. The proportion of men to women, 69 to 81, is more nearly equal, but this difference is largely an artefact resulting from the fewer accommodations in the hospital for men, and also because there is some selection in the type of cases ad-

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mitted. There were 49 complete recoveries, which have, for the most part, been verified. This recovery rate is one-third of the total cases and conforms with Kraepelin's estimate for the manic-depressive group as a whole, but is considerably less than that of Dreyfus's series. Possibly the recovery rate in the present group would be somewhat higher if the subsequent history of the 76 patients who left the hospital unrecovered were known. As a matter of fact five are known to have recovered, and one of them recently returned to the hospital, after a five-year interval, in the second depression which is in all respects similar to the first one. Excluding five cases of exceptionally long duration, one of whom was 14 years depressed and recovered after five months' manic phase, the average duration is eight and one-half months. This is certainly not an unusually long duration. The menopause was coincident with onset in 18 cases only. Seven of these recovered. In neither those who recovered nor in those who did not was there a particular symptom complex which seemed to be due to the menopause as such. Evidence of arteriosclerosis was positive in one-fifth of the cases and was present in eight of the recoveries. Seizures were recorded in seven instances, and in one who recovered it is noteworthy that a paresis and an aphasia developed and passed off while the patient was in the hospital. Recurrent attacks of depression and excitement are known to have occurred in 18 instances.

Assuming the anxiety-unreality complex and the expression of absurd ideas in the presence of mental clearness to be pathognomonic for these late depressions, particular attention was paid to their frequency in this series, especially in those cases which recovered. Nearly one-half of the patients at some period of their illness manifested an anxiety state, and it is significant that it was present in more than one-third of the cases which recovered. Feelings of unreality as well as the expression of absurd ideas were so infrequent as to have weight only by their absence. An important factor which other writers have not seemed to lay much stress upon is the presence or absence of clouding of consciousness. As noted above, it is held that mental clearness is the rule. The present study finds, however, that one-fourth of the total cases, and nearly one-half of those who recovered, were definitely clouded. Prognostically, this may have some value; at

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least we get the impression at McLean that those cases which show confusion are apt to have a more favorable outcome. Finally, although there may not be a fundamental metabolism disorder at the bottom of the involutional disturbances, nevertheless it is a matter of experience that during the course of a depression or an excitement there is often a marked fluctuation in body weight. In the present series of 49 recoveries, 32 patients gained 10 or more pounds, while those who remained unrecovered did not show so favorable a proportion, some even lost weight. It would be presumptuous to correlate this variability in weight with the physiological involution, but from a prognostic standpoint it would seem that if those patients who are at the involution period with their first mental attack preserve their ability to metabolize abundant nutriment, their prospects for recovery are more favorable. It is not to be inferred that a gain in weight always means a favorable outcome for the psychosis, because, as is well known, there are many cases in which the increase in weight is out of all proportion to the mental improvement and where it would seem the adiposity became a component of dementia. Prognostically, however, in the present series, it was noted that those cases which were destined to recover began to gain in weight some three or four weeks before mental convalescence set in.

From the foregoing the following summary is made:

The factors which underlie the physiological involution are obscure. Because of this obscurity it has not as yet been determined that manic-depressive attacks first occurring at the involution period are modified by it in any unusual way.

First attacks of manic-depressive psychosis occurring at or after the age of 40 conform to the manic-depressive group as a whole with regard to recoverability and duration. Depressions predominate. Women are more often affected, but the menopause does not modify the course in any particular degree.

Although no pathognomonic symptom complex in the nature of pure anxiety-unreality states were noted in this study, a good proportion of cases did show anxiety, but its influence upon outcome is not remarkable.

Prognostically, those cases which during the course of their illness show mental confusion and which are capable of gaining bodily weight seem to have a more favorable outlook for recovery.

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THE SO-CALLED LUCID INTERVAL IN MANIC-DEPRESSIVE PSYCHOSES. ITS MEDICO-LEGAL VALUE.

By ALFRED GORDON, M. D., of Philadelphia, Pa.

One of the most important chapters in the history of manic-depressive psychosis is the state of mentality during the intervallary periods, when the individual between isolated outbreaks of excitement or depression is apparently lucid or may give a strong impression of a normal mental attitude. This particular phase of the patient's pathological life invites serious reflexion which must be based upon accurate observation, as it involves grave medico-legal problems. First of all one will not infrequently be confronted with this question: should an individual who has had two or several periods of depression or exaltation be left at large and not be confined during the phase of the so-called lucidity? In the next place, is such an individual, if not committed, to be considered mentally competent to take care of his affairs? The two queries lead us logically to the consideration and proper appreciation of the mental status of the individual during the intervals free from the depressive or manic attacks.

There cannot be any doubt as to our attitude towards the diseased individual during the depressive or manic states. The state of passivity, of absence of initiative, of inertia, of self-negligence during the period of depression naturally renders the patient dangerous to himself, and because of these special characteristics he can be easily influenced, so that his own property and belongings may be seriously compromised. During the maniacal phase there is a general tendency to an overactivity in every direction, to extravagance which may naturally lead to a deplorable initiative in various undesirable enterprises with highly prejudicial consequences. Every one of us is familiar with instances in which fortunes have been dissipated and families left destitute by maniacal individuals whose maniacal phase had not been sufficiently conspicuous in the gross sense of the term and recom-

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mendations for commitment had been ignored by both court and relatives.

Not infrequently we meet with patients who have been suffering from mild unrecognizable attacks of either depression or excitement, who at first glance do not appear to be insane, who speak quite reasonably on many subjects, whose claims appear to be legitimate and who at the same time are suffering from a psychosis in which precisely because of the abundance of ideas and because of the overflow of intelligence in their manic phase they are capable to think, feel and act in a manner which may be prejudicial to themselves and to all concerned.

In considering intervallary periods, it is to be remembered that there are cases in which they are long (from months to years), or very brief (from hours to days), or else there are cases without intervals. I have on my records several cases in whom the alternating phases lasted but 24 hours without a trace of an intermediary period. The chief problem to solve in my present attempt is to determine whether there exists a genuine lucid interval and what should be our attitude during that interval.

The opinions of authors on this subject are divided. Some competent observers believe that there may be a complete return to normal mentality in the intervals. Others equally competent hold the view that if there is a mental integrity it can be only at the beginning of the psychosis after the first or second attack and that it disappears after multiple attacks. There are still others who deny all possibility of lucidity between individual phases of depression and exaltation. Such a diversity of opinions is certainly most striking. Is it due to the fact that the majority of patients who fell under observation of the first group of psychiatrists happened to have unusually long remissions and those of the second group were of a less favorable character, finally, those of the third group of observers presented the most unfavorable class of patients? If such is the case, and all the evidences point in that direction, we must admit that there must be a great variety in the duration and character of the remissions, also in the regularity of their occurrence. While an outbreak of an individual phase of the psychosis may occur at any time, nevertheless there are cases in which both phases or one individual phase of the psychosis make their appearance with a remarkable regularity as

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far as period of time is concerned. A young girl, for example, during my observation of six years had every spring and fall attacks of depression which would last six weeks. Another patient, married, had, to my knowledge, during a period of 12 years regular attacks of marked depression for three weeks, immediately alternating with a mild exaltation for six weeks every year, commencing in December. If a regularity in the onset and in the duration of attacks is observed in one group of cases, in the majority of instances such a regularity does not exist and any individual affected with manic-depressive psychosis is at all times, and always threatened with an outbreak or, to say more precisely, he is in a constant state of morbidity. It seems logical to contend that no matter how satisfactory the state of mental health may be during the intervallary periods, the disease nevertheless exists at that time in a state of potentiality and may be reproduced at any moment without apparent cause. This conclusion naturally forces itself upon us when we consider that irrespective of the form and the intensity of the disease, the succession of the phases of depression and exaltation is always identical in every possible case. The affection, consequently, persists and never varies during months and years. By reason of these invariable recurrences can we therefore pretend that if there are times when possession of mental faculties apparently returns, that this possession is so genuine, so full and so absolute that the individual could be considered free from the original disease?

In the following two histories, I find illustrations of what may constitute normal mentality during the intervallary periods of manic-depressive psychosis. The apparently lucid intervals were so long, between two and three years, that the patients were considered by many as possessing a normal mentality.

CASE I.—C. Y., physician, aged 45, had always been nervous and highly irritable. Because of his disturbing temperament his domestic life was most unhappy so that a separation from his wife was inevitable. Two of his three children were mentally defective. As a man of intelligence, he fully realized his misfortunes and his inability of adapting himself to circumstances. He became depressed and found himself incapable to attend to his duties and to continue his work. The depression became gradually deeper and he isolated himself. Indifference to surroundings and to himself, apathy, finally total passivity to all absorbing and interesting events—this was the condition of my patient which lasted seven weeks.

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Gradually the depression subsided. He soon became talkative, began to ask questions and to take an interest in conversations of others. Then he began to complain and find fault with his attendant. When once the latter could not for good reasons bring in a blanket at the patient's instant request he struck him over the head. At another time he threw a plate with hot soup at the maid, because she brought in the tray a few minutes later than he expected. He soon became very talkative, restless, agitated. He refused to be accompanied by an attendant. He then visited several publishing houses offering to write books on sociological topics. He made acquaintances with the greatest ease, irrespective of the character of the individuals. To strangers and to every one whom he happened to meet he narrated his dissatisfaction with his family and that he was not sufficiently appreciated by all. He could, he said, make considerable money from various schemes—and make everybody happy. He did not worry because "he would arrive at great prominence." While dining in a restaurant he threw a plate at a guest because he overheard him making a remark about Colonel Roosevelt. He was arrested. His condition was recognized and he was legally committed to a private institution for the insane. For three months he was struggling to regain his liberty by sending communications broadcast to all men prominent in public life. He was in a constant state of agitation, and could not sleep. Gradually all these symptoms commenced to subside and within four weeks the state of excitement had totally disappeared. He remained in the institution another two months and was discharged, after persistent requests of his son, but against my advice.

For a period of two years he remained at liberty and during that time I saw him every two or three months. This period of freedom from the phases of depression and exaltation was most interesting and instructive as it throws some light on the so-called "lucid interval." The patient appeared calm and composed. He spoke on the events of the day with an apparent perfect knowledge of all happenings, domestic, national and international. He often referred to his effort to regain by reading what he missed during his confinement in the sanitarium. At each examination he mentioned with regret the loss of his former practice of medicine which was very remunerative. He led a very regular life. As he was very fond of music, he frequently went to hear recitals and operas. He did not miss public lectures on general topics with the object, he said, "of making up for the lost time while he was ill." As a man of good general education, he frequented libraries and read considerably. He renewed his former acquaintances and everyone considered him perfectly normal. He was apparently contented and satisfied with his "regenerated life," as he called it.

To all appearances therefore, the man could be considered as perfectly able to control his own affairs, and therefore, legally as possessing full civil capacity. In the midst of his apparent lucidity he planned to resume his practice of medicine. But the judgment exhibited in this particular respect was decidedly deficient. After having been for a number of years

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in general practice with the usual occasional work in minor surgery he now conceived a plan to resume practice and commence at once with major surgery. He would, he said, send out notices to a number of physicians, former friends, and others, informing them of his new intentions and asking them to refer cases to him. When reminded by me of his utter unpreparedness for such a work, and of the utter moral wrong to undertake operative procedures on a human being, without years of special preparation, my patient found my remarks somewhat offensive to him, and during a second conversation expressed to me his indignation at my interference. Besides, the impracticability in expecting physicians to refer important work to him he could not see. He kept on persisting in demonstrating to me his proper attitude in the matter. My firm position in preventing him from resuming practice in any form, whatsoever, he commenced to view with a certain degree of incredulity and even of hostility. As he was in need of money, and his brother refused it to him, because of my attitude in the matter, he then abandoned temporarily the idea of practice of medicine and turned his attention to literary work. While he never before wrote anything for publication, he has now conceived an idea of writing a treatise on the psychology of sex. Neither by his general or special education, nor by his make-up (I knew him quite intimately for a number of years) was he fit to write on psychological subjects. He informed me of his work some time after he commenced it. He spent many hours in libraries which proved to be detrimental to his physical health. At once I discouraged this undertaking, pointing out the man's unfitness for a work of this character. He felt disconcerted at my announcement, but did not express any special indignation this time. He followed my advice, gave up the work, not because he was in accord with my views, but because, as he said, he did not care to have trouble with his brother who always followed my advice. One by one, he took up other plans, for which he was not prepared. One of such plans was particularly striking, namely, he wished to do banking. He would interest some people in it and become himself president of the institution. As he himself had no money whatever, and as he knew nothing of financiering, his proposition and the persistence in asserting his ability to lead the business to a successful end was most astonishing. Yet the manner of speaking and the general behavior could not impress any one with anything but a normal mentality. Soon he again commenced to speak of resuming the practice of medicine in the same way as he spoke before. At the time of writing these notes, over two years have elapsed since he had his manic-depressive outbreak. All this period of time he has been considered by every one as perfectly sound, as indeed his mannerism and his general information are those of normal individuals. If, however, we consider seriously the above-mentioned data, we cannot help but admit that there is a fundamental disturbance in judgment, and in the sense of obligations. Could or would a man with a normal mentality permit himself to practice operative surgery of the major type without the least preparation for it? Could or would such a man expect any one to send him cases for that purpose, knowing

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well that his fellow physicians were familiar with the character of work he was doing before his illness? Would a normal individual conceive an idea to become suddenly a president of a bank, without any knowledge of financiering; or would he think of writing and publishing a book on psychology and sell it successfully, just on the mere wish of doing it? It was evident that my patient was essentially ignorant of his own inaptitude. He always wondered at the reasons of my persistent opposition to his undertaking. He was certain and convinced of his ability of carrying through his plans. Moreover, in his arguments against my advice, he maintained the attitude of unquestionable intellectual and moral superiority. When it was pointed out to him that he would commit a great moral wrong in operating, if permitted, on human beings, without having ever performed an operation and without having had the proper training, he could not see the solemnity of such an admonition on my part. He persisted in having full confidence in himself and would not admit that he could commit an unreasonable act. There was a manifest break in the man's mental equilibrium and in his feeling. While prior to his psychosis he was attached to his brother and appreciated the latter's generous spirit, now these sentiments underwent a radical change. His brother's illness did not affect him in the least. His son's accident, which was followed by a fracture of the femur did not disturb him much. There was also noticeable in him a tendency to presenting facts in an inaccurate manner and in speaking about others in a most uncharitable manner, while prior to his illness he was considered as the most deliberate and honorable man.

CASE II.—Miss M. C., age 29, teacher of languages, had a mild maniacal outbreak of three weeks' duration. Six months later she had another attack, but of a somewhat more pronounced type which lasted seven weeks. This was followed by a remission in which she still is, and which has been in existence 27 months. According to the information obtained from her mother the patient had one attack of depression of eight weeks' duration, one year prior to the first maniacal attack.

The patient has been under my observation since the first maniacal phase. During the first interval of six months' duration and during the 27 months since the last attack, the patient's mental condition was identical. To all appearances the patient was free from that exaltation which was characteristic of the individual outbreaks. There was no tendency to quarrel, no restlessness, no talkativeness, no desire to attack—all symptoms which she exhibited during the attacks. She was calm and composed, without a trace of depression. She attended meetings of an intellectual character. Being a musician she attended concerts very frequently. Questioned, she always replied that she was contented and quite happy. She did not complain. Her former friends have all commenced calling on her and inviting her to various affairs. She resumed her former life with the exception of teaching. She was very anxious to begin the teaching, but upon my advice, her mother did not permit it. My reason for giving such an advice was the conviction that her mental condition did not appear to

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me perfectly normal, although her mother and all her friends considered her totally restored. First of all, she became very egotistic, which trait was not conspicuous in her character prior to her illness: she was considered extremely good-natured and she was always ready and prompt in rendering a service. She was well known for her unlimited affection for her mother, but now she became indifferent to her pains from which she suffered because of her chronic rheumatism. At times she even appeared callous; once in bed she would refuse to get up to make her mother comfortable. She was easily irritated. Contrary to her good naturedness to every one, for which she was well known, she became ill-natured, found fault in others, attacked the morality of her friends, and was careless in making statements. To deceive she did not consider as a wrong. What was particularly noticeable is an unusual optimism in all thoughts and acts. She fostered the idea of being capable to undertake almost anything she wished and that she could handle most difficult problems in every sphere of life. She invested some money in two different enterprises without her mother's knowledge. In spite of her high opinion of her own abilities she made these investments without the least investigation as to the nature of the enterprise and to the character of the individuals who solicited the investments. In spite of the fact that in every-day conversations, and for all practical purposes the patient had been considered by all as being mentally sound, in spite of the fact that at no time during 27 months had the patient presented any evidence of her former manic-depressiye psychosis, nevertheless, in view of the above characteristics concerning her power of judgment, her sense of morality, her affectivity, her excessive confidence in herself, her change of attitude towards her friends—for all these reasons my patient's mental condition appeared to me morbid.

Two cases, among others described here, illustrate with sufficient evidence, I believe, the value of the so-called " lucid period " in the life of an individual with a manic-depressive psychosis. It proves the fact that at least in some cases the lucidity may be only apparent, and that where a superficial judgment will fail to reveal a mental disorder, a careful analysis associated with a prolonged observation of the patient's entire life and of every act in his daily life will unearth an entirely different picture of his mentality. It will then show that while the characteristic elements of the psychosis are no more in action, the disease nevertheless produces such a disturbance in the patient's mode of thinking, of reflecting, of co-ordinating ideas, in the manner of viewing moral obligations towards others, etc., that he cannot be considered normal. The two cases related here are highly instructive from this standpoint and they demonstrate with evidence that no matter how intelligent and reasonable the patients may appear, one may

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commit a gross error if a more detailed and frequently repeated investigation is not made. It may happen that their marked intelligence itself is an evidence of the disease. Appearances are fallacious and they alone cannot decide an opinion. Insanity must be judged not from what is left of reason, but from what is wanting.

If it is true that there are cases in which serious changes of mentality are present in the intervals between individual outbreaks of depression or excitement, there are also cases in which these changes are less pronounced, cases in which the changes are at a minimum, cases with but one or two outbreaks during a period of many years in which the patients eventually made a total recovery, cases in which the intervallary periods are either very brief or very long. As to the number of individual attacks of the psychosis, an equally great variety is observed. There are cases in which but one or two attacks occur during a period of many years; cases in which one or several attacks occur yearly and for many years. One of my patients who is now 52 years of age has had, since the age of 20, every year or every two years one or two attacks of depression lasting from one to four months and rapidly followed by a mild manic condition of shorter duration. Between these two extreme limits of frequency, we observe variations in the greater or lesser number of outbreaks. Have the number and the frequency of the latter any bearing upon the duration of the disease? Has the duration of the intervallary period any bearing upon the patient's mental condition during that time?

It must be generally conceded that brief intervallary periods are but intermissions characterized by a greater or lesser amelioration of the symptoms of the psychosis and not by a return to normal. On the other hand prolonged periods of so-called lucidity are not an absolute guarantee of recovery, as the two above described cases attest it, although generally speaking, intervallary periods of many months' duration present *à priori* a greater chance and greater possibilities for recuperation and restoration of normal mental faculties. For the same reason the greater or lesser duration of the individual's phases of the psychosis has presumably a corresponding influence on the intensity of the mental disorder during and after the outbreak. It appears therefore logical that for a proper estimate of the mental status of a given

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individual during the lucid periods consideration should be given to several elements, namely: the frequency of occurrences of the psychosis, the duration of the individual phases and duration of the intervallary periods. At the same time observation shows that neither of these elements possesses an absolute diagnostic value and that in any given case no absolute prediction with any great amount of certainty can be formulated in advance. There are cases with very few outbreaks of the psychosis and still a profound mental disorder may develop. There are cases with a greater number of individual attacks and yet the mentality in the intervals is not greatly affected. There are also cases similar to those described above in which in spite of prolonged intervallary periods the mentality may be fundamentally involved. It appears therefore that no absolute rule could possibly be established and each given case must be individually interpreted and an opinion as to the mental status must be based mostly upon the results of repeated examinations of the patient during the "lucid" interval. The degree of intensity of mental damage or else the possibility of complete restoration to normal depend, besides the above mentioned factors during and between the individual attacks of the psychosis under discussion also and apparently mostly upon the affected individual's personal or hereditary mental qualification, inherent so to speak. Indeed the natural mental attitude of the individual which constitutes an integral and an inseparable part of his entire makeup seems to play an enormous rôle in the failure of adjustment, hence in the causation of the psychosis; also it has, I believe, its greatest influence on the mental status after the manifestations of the individual phases of the psychosis have subsided or disappeared. The attacks of mania or of depression are *agents provocateurs* for deeper disturbances in the mentality which had been since birth constitutionally below normal. The infinite diversity in the degree of the mental deviation (constitutionally speaking) explains the great variability in the mental status of individuals who had previously suffered from outbreaks of the psychosis.

This observation has a considerable bearing upon the medico-legal side of the problem of "lucid intervals" in manic-depressive insanity. Two questions present themselves for consideration in this respect: One is that of commitment, the other is that of recognition or non-recognition of the individual's civil capacity.

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In view of the variations in the mental status of individuals presenting the so-called lucid intervals in manic-depressive psychosis the question of commitment naturally cannot be solved in a uniform manner. A mental condition such as seen in the two cases described above in spite of the fundamental changes does not require commitment, because its various manifestations are not of an order to create undesirable or dangerous conditions to others. As to a possible danger to themselves, they require protection and surveillance as the defective judgment and defective moral conception render them an easy prey for undue influences from any source. Such individuals can be easily controlled by their families. In other cases, especially when the so-called lucid periods are very brief, we observe practically a continuation of the manifestations of the psychosis itself, but in a greatly attenuated form. If commitment is not absolutely indispensable in every case, it is nevertheless indicated in some cases when the patients are susceptible to commit antisocial acts. Finally, there are instances in which the outbreaks of the psychosis are so frequent and the apparently lucid intervals are so brief that the patient is practically under a constant and continuous influence of the psychosis so that the intervallary period could be totally ignored. Such patients are a constant menace to society and to themselves and commitment is indicated and is the only issue.

If in a certain group of cases commitment is not indicated because of the presence of only very few morbid manifestations or because of absence of evident mental disturbances all patients during the so-called lucid intervals should nevertheless be kept under observation. As it was shown on the foregoing pages, in spite of an apparent lucidity there may be such essential and fundamental deviations in the power of judgment, in the conception of obligations, of duty and in the general activity that if the patient is abandoned to himself he may gravely compromise his own material situation and that of his family. Such an individual is not fit to care for his affairs, he may at any moment make an extravagant or unnecessary usage of his small material resources. Not infrequently we meet with cases in which the apparent lucidity is so deceiving to the family and to the judicial officer that the patient's activity is not interfered with and his family is left too late without resources. One patient who is still under my care was

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permitted and even advised by the family physician to get married during a lucid interval, with the result that he wasted the largest part of his wife's fortune on various, most unwise enterprises. If commitment to an institution is not always indicated or advisable, we nevertheless must not forget the fact that in the largest majority of instances during the so-called lucid intervals, the patient's civil capacity is questionable. Even in the most prolonged and most favorable intervallary periods patients who have had outbreaks of manic-depressive psychosis should be considered as possessing a mentality which first of all is predisposed to undergo profound changes at any unexpected period of time. In every instance they should be provided with administrators or with counsel who should be given full power of a guardian in order to protect them from outside influences and to prevent them from carrying on all new undertakings without a thorough investigation. No illusion should be entertained with regard to the value of pretended lucidity which in the majority of cases is problematical. Each case must be studied individually and due appreciation be given to every manifestation no matter how slight it may appear. It should be invariably borne in mind that an individual with a previous history of attacks of manic-depressive psychosis possesses an underlying morbidity upon which the psychosis is grafted. There is a fundamental disturbance of equilibrium in the mental and moral spheres. Such an individual is of unstable and irritable disposition; he is suspicious, quarrelsome, egotistic, penurious, defiant—all peculiarities which may lead to impulsive acts of a regrettable or criminal nature. These characteristics cannot naturally disappear during a so-called lucid interval no matter how protracted its duration may be. In forming an opinion therefore one must rely on the entire life history of the individual, on the mental condition during the intervallary period and on that before the psychosis developed.

DISCUSSION.

DR. HILL, Iowa.—Mr. President, I might state a case which I think is remarkable. It is that of a German, a tailor by trade, who was a successful man. He came to this country at the age of 20, but when he was 25 he became insane, a manic case. After remaining in a State Hospital for seven months he made a complete recovery, afterward he got married, had three children, all of whom are still alive. His wife died

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last August. He has had nine attacks, all manic, none of them depressive; and on an average he has recovered from each attack after five months treatment; so that in 45 years he has been nine times in an institution for treatment where he was obliged to go on account of disorderly conduct; but during the 45 years of his insanity he has acquired $100,000 in real estate and other property. His wife had been his natural guardian, and at times she was his legal guardian when he was not in an institution; yet he was considered sound in mind after his attacks, and carried on his business successfully. His wife died at the beginning of an attack last summer and no one else felt like interfering. The result was that one month after his wife died he married the second time, and it was necessary to place him under treatment again. He has made a good recovery from the last attack; but now, being 68 years old, the guardian of his property has been made permanent, and I have been made the permanent guardian of his person. He is in his right mind, of normal senility with some mental impairment.

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IMPULSIVE ACTS IN THE PARTICULAR FORM OF SWALLOWING FOREIGN OBJECTS, AS MET WITH AMONG THE INSANE.

By A. W. HOISHOLT, M. D.,

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Every human being is endowed with certain elementary cravings, congenital in origin, and of the greatest importance to the maintenance of the human body, such as the nutritive, the sexual and the self-preservative. Of these elementary cravings the one for food bears at least a physical relationship to the impulsive acts with which this paper will deal.

The natural requirement of the body to replace lost energy by taking into the body new material for its maintenance causes the feeling called hunger or the craving for nourishment.

This craving takes a normal course, running parallel with the ups and downs experienced by the human being during health, but it becomes pathological whenever it is excessively diminished or excessively increased, whenever it does not show an exercise of choice, or a loathing for the unclean, but especially when it becomes completely diverted from the nutritive craving to ideas diametrically opposite to the sustenance of life—under the influence of fallacious ideas of one kind or another. Sometimes the ideas leading to the introduction of substances into the stomach are based upon a pathological feeling, such as the craving of the hysterical for attention. At other times the impulse is still more diverted and utterly devoid of logical motive, as when a case of dementia-præcox purposelessly and triflingly forces foreign substances into his pharynx and esophagus. In the case of the hysterical, the abnormal psychotic state, which is present at the moment the craving is experienced, gives to the impulse so great a force that the mental reflection which would oppose the execution of the act does not arise in consciousness, or does so only in a fleeting manner. This was the case in a patient of the Napa State Hospital, suffering from hysterical insanity, whose im-

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pulsive acts consisted of the swallowing of a variety of foreign objects. She had done this on at least two occasions as far as we now know. The first one occurred in April and May, 1912, as reported by Dr. A. C. Matthews, of the Napa State Hospital staff, in an article published in the *California State Journal of Medicine* in January, 1913. At that time 1149 foreign bodies were removed by Dr. Matthews from the stomach on May 17, 1912, the patient making an uneventful recovery. From 1912 until the fall of 1915 the patient continued to be an inmate of the hospital, subject to spells, during which she would show restlessness, moodiness and morbid jealousy. Whenever her patient-friends seemed to her to be favored by a nurse or a physician she would show hypersensitiveness and would become exceedingly jealous, usually taking offense at trifling occurrences. She gradually, however, improved until she was able to work outside of the institution, at the end of the above-mentioned period. In the course of months, during which it seems she was given work which overtaxed her strength, the nervous symptoms again showed themselves and she was returned to the institution in a condition of excitement. During the month of May, 1916, she appeared to be absent-minded and seclusive, as well as restless and despondent; but after a while she became brighter, took special interest in the work of the arts and crafts department of the institution, until September of this year, when she began ailing physically and a tumor-like mass was discovered in the right epigastrium, which upon X-ray examination proved to be a mass of foreign objects. Photographs of the X-ray plate and of the foreign objects afterwards removed are herewith appended. The operation instituted led to the removal of 921 objects consisting of pins, safety pins, nails, a breast pin, etc. After her recovery from the operation she gave a past history showing that she had been in a dream-like state for a month or more in the spring, during which she had swallowed these articles; not afterwards remembering what things, at what time, or why she had continued to swallow them. All she remembered was that she at that time had a feeling of despondency at not being allowed to see her friend, and that she wanted the nurse to feel sorry for her. When told that unclasped safety pins had been found among the foreign objects, she stated that she remembered wrapping safety pins with tissue paper after un-

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clasping them, so as to facilitate the swallowing. She wanted the safety pins to open in the stomach so that they would hurt her.

A case of somewhat similar nature occurred in the hospital about two to three years ago in which the patient showed outbursts of fury with tendency to do harm to others and to feign attempts to do away with herself. These outbursts at first lasted a few days, later only a few hours. They were associated with peculiar fallacious ideas which the patient herself recognized as fallacious. She would at times pretend to faint, and, as she herself described her feelings afterwards, would enjoy seeing the nurse put to the trouble of carrying her to her room, undressing her and putting her to bed. She sometimes tried to hurt herself by biting her arms, etc., but always seemed to take care not to hurt herself very much. The furious outbursts were attended by a feeling of despair, during which she would try to disfigure her nurse with any possible means at her command, and after a few minutes or hours would apologize and explain that she was jealous of the good looks of the nurse. On Xmas day, 1914, at a time when the patient was rather cheerful, she asked the nurse to let her celebrate Christmas by drinking out of a glass instead of a tin cup. The nurse yielded and when the latter had thoughtlessly left the glass in the window and absented herself for a few minutes, the patient managed to break the glass, taking pains to make little noise, as she afterwards explained. She could not, however, remember clearly what happened after that. When the nurse returned and found blood on the pillow she examined and discovered glass in the bed. Every particle of glass was removed from the room and the patient was under complete restraint for a time, during which she passed by the bowel 23 pieces of glass, some of them over an inch in length with sharp edges and points. The patient states that she does not remember experiencing any pain from a cut she received on the lip, or from the swallowing.

The first-mentioned case is a typical one of hysterical insanity, and the second case has a great many of the features of this form of mental disease. The imperative or impulsive acts in these cases appear to have been carried out in states of befogged consciousness, or dream-states, under the influence of understandings and desires with which the patients had been occupied during their more normal states, but which inclinations they at

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such times could overcome by rational reasoning, as afterwards explained by them.

Besides the above hysterical cases we had last year two patients that swallowed foreign bodies, one of whom at least was a katatonic. In these cases the impulse was without visible motive, or recognizable aim, and apparently without the struggle of contrast ideas met with in hysteria. In katatonia as well as in epilepsy, in fever deliriums and in mental confusion, we observe an explosive suddenness of the act in attacks on others, or, as in these cases, in acts directed against themselves, which is characteristic of an imperative act.

The first of these cases is that of a young man of 32, who had presented typical symptoms of a dementia præcox. In May, of last year, a teaspoon was missed in the ward of which he was an inmate, and he was finally suspected of having hidden it. When questioned he said he had "swallowed it," and repeated the same answer when asked about a half-dozen missing links of bed springs. An X-ray examination revealed the presence of a teaspoon in the left epigastrium, and the links of bed springs in the region of the appendix, as shown in the accompanying X-ray photo. These articles were removed by operation in June, of last year, the patient making a rapid and uneventful recovery, his mental condition remaining unimproved. The patient continued to be perfectly comfortable physically, although a second X-ray examination showed that there were two more bed-spring links in his bowels in the region of the sigmoid flexure.

The fourth and last patient had not been diagnosed mentally when symptoms of appendicitis were discovered. The laparotomy resorted to revealed the protrusion of the handles of two teaspoons from a perforation of the ileum about two inches above the ileo-cœcal valve. The patient died eleven hours after the operation.

CASE I.—A. B., white, female, age 35, married, two children. Admitted March, 1912.

F. H.—Father's brother insane. Father and sister said to have been eccentric.

P. H.—Physically healthy when a child, but always more or less nervous; was subject to nightmares. When a girl, fainted from fright and suffered from cramps at the time of menses. She has never had attacks of aphonia, nor does she remember having had cravings to eat unusual things. When

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she was 20 years old she was reserved and seclusive and very wilful—would not listen to reason. Said to have had a previous attack in 1908, lasting four or five months. At that time was unable to sleep; cried and screamed continually, and worried over trifles; was taken to a sanitarium where she remained one month. Often complained of fullness in the back of the head and around the ears. Two weeks previous to the beginning of the trouble had been visited by a physician on account of slight rash across one breast and was told that she had syphilis. After three weeks' treatment with mercury the mental attack of 1908, described above, intervened.

Previous to admission patient worried considerably over her baby who had been operated on for strangulated inguinal hernia; also worried about a baby that was born two months later, and was a "blue baby."

On admission the patient was well oriented, had good grasp of recent past, etc., and responded excellently to the usual tests. The physical and neurological examinations showed practically nothing excepting the fact that she was rather nervous and slightly emaciated.

The present attack began gradually, about September, 1910. The patient heard voices and music, saw bright lights, felt persecuted, was hysterical, had attacks of crying, said she wanted to hurt some one; placed hands on child's neck to choke it, but changed her mind. Said she felt impelled to do acts which she knew were wrong.

After admission patient was very restless and paced the floor constantly; was distinctly depressed. Said she was unable to control herself. On two occasions broke windows and destroyed bed clothing, and on one occasion tore sheet into shreds and made same into rope, which she wound about her neck. While on a walking party she intentionally scratched her hand severely on a barbed-wire fence.

Often complained of insomnia and at times had hallucinations of all the senses, which she recognized as such. Spent many hours writing emotional letters in fine copper-plate hand, usually making requests to see the children or be allowed to go home.

On May 16, 1912, gastrotomy was done and 1149 foreign bodies, weighing one pound and two ounces, were removed; consisting mostly of safety-pins, hair pins, buttons, nails, parts of teaspoons, and many small pins. Recovery was uneventful. Under treatment patient gradually improved.

On July 10, 1913, she was sterilized as she was anxious to be given leave of absence and an opportunity to make a living outside the hospital.

During part of 1914 and 1915 she did housework in a family living near the hospital and got along fairly well, but continued to show nervousness and hypersensitiveness, frequently calling on the superintendent for sympathy and advice whenever she had taken offense at or had become jealous of this or that person in her immediate surroundings.

While living with this family she had to be humored in every way, or she would become moody or irritable. She finally became so nervous, and unable to control herself, that she was returned to the institution, about November, 1915. In March, 1916, she was again enjoying parole of the

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grounds, but when she violated the rules of parole and lost it, she had an outbreak of irritability—tried to provoke her nurses by acts of untidiness and had crying spells. About August 1, a large mass was discovered in the right epigastrium, which made her physician suspect presence of foreign bodies in the stomach. This was verified by an X-ray examination on September 20. On September 29, Dr. A. C. Matthews again opened the stomach and removed 921 foreign objects, consisting of the following articles:

Small pins	412
Hair pins	45
Nails	70
Broken hair pins and small wires	145
Large safety pins	45
Small safety pins	47
Screws	8
Brass-headed tacks	10
Broken safety pins	28
Shoe buttons	3
Buttons	4
Pieces of corset steel and tin	54
Large beauty pin	1
Piece of spoon	1
Small pebbles	10
Pieces of hose supporters	5
Hooks and eyes	14
Pieces of glass	11
Pieces of chinaware	5
Large sewing needle	1
Pieces of thread	2
Total	921

She made a good but somewhat slow recovery, and was able to be up after five or six weeks.

When she was interviewed about three weeks after the operation she said that she had noticed that whenever she became very nervous and upset she did not remember things that had happened, and when she got over these spells and looked back the past seemed like a nightmare to her. She thought she began "to swallow things" in April or May, 1916. "It seems so distant now—just like a dream. I can recall one thing sometimes, when something else will occur to me. I remember one afternoon that I was literally feeding on pins—but I don't remember what week or what afternoon it was, or at what time in the afternoon, or what else I swallowed. I remember one time swallowing a big nail. It seems an impossibility now that I should have managed to do so. I remember it was large, but not its color, nor when I did it, nor whether I felt any pain as it went down into the stomach. I remember that I swallowed the things because I thought I would make myself physically ill so that the nurse would feel sorry for

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me and give me more attention, etc.; and keen disappointment at not being allowed to see my friend, I think, also put me in the mood to do it." When she was asked if she had not swallowed a breast pin, she said: "I barely remember something like that, but I don't remember what it looked like." She experienced visual hallucinations at times: "Sometimes I would see forms of beautiful children before my eyes and I would see faces which sometimes would become distorted. When I look back upon my nervousness in the past I find that I always experienced an internal nervousness which I tried in vain to suppress." She complained at this time of a choking feeling or a feeling of something tightening inside of the lower jaw when nervous. A feeling of precordial pressure and paraesthetic sensations with marked tremor of hands and fingers were recorded. The surface of the palate seemed anaesthetic, but no anaesthetic zones in skin were ascertainable at this time. We have not been able to detect a contraction of the field of vision since she swallowed the foreign objects, but a marked inversion of the color fields has been found present.

CASE II.—C. D., white, female, age 31, single, student. Admitted May, 1914.

F. H.—Family reticent as to history.

P. H.—Patient has always been very nervous and self-willed, going into tantrums when a child on the least occasion. Of late years has been overworked; an unhappy love affair occurred just before she was sent to the hospital. Physical, including neurological examination, negative.

Her mental disease began suddenly, and she attempted suicide eleven days afterward, day before admission.

On admission patient was very restless, cried and screamed, tried to break and butt down doors, and attempted suicide by butting head against wall and by strangulation, but this effort did not seem to be seriously intended. She accused herself of having committed sin for which neither God nor man could forgive her. Her condition was very changeable—the violent outbursts lasting for days, separated by quiet lucid intervals of one week or more. The violent spells were attended by noisiness and erotic excitement, but even at such times she would, during short intervals, talk in a lucid and coherent vein. No evidence of negativism or stereotypy. During the long intervals of quietness she would show self-control and rationality—would enter into intelligent discourse during which she would even give evidence of sharp wit and bright intellect.

In February, 1915, she began to give expression to a few fallacious ideas: "The warm packs were taking away her brains, etc." About this time she bit the thumb of her nurse in a violent spell and threatened to kill her folks for putting her in the hospital; complained of burning sensations in the head and even talked of suicide during quieter moments, especially of her attempted suicide prior to coming here, becoming desperate about it, and would at such times become very noisy, saying: "The only way to end it all is to shoot myself." In April, 1915, she on one occasion put her head and neck under the strap of the restraining sheet and called for help.

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She was found unhurt except for a slight bruise on her neck. During May, 1915, she seemed to become more and more irritable, cursing every one and giving expression to persecutory ideas. She would sometimes pretend to faint, enjoying seeing the nurses put to the trouble of carrying her to her room, undressing her and putting her to bed.

Spells of furious excitement continued throughout the summer and fall of 1915. She was as before very noisy, would try to bite or get her fingers into the nurse's eyes at times, and frequently required restraint to prevent her from biting her own hands and arms. She would scream because she said that she had lost all sensation of pain. In her despondent moods she talked about the easiest and least disgraceful way of committing suicide; said that she did not have the moral courage to drown herself but hoped that it might happen accidentally. She would knock her head against doors and windows as if to kill herself, but seldom bruised herself much.

During the past year the patient seems to have improved slowly but steadily, and attacks of violence have been absent for the past six months. She has become much interested in arts and crafts work, and is now in every way well behaved, hoping to leave the hospital very soon. No deterioration in intelligence can be detected.

On December 25, 1914, she seemed rational and cheerful. When a tray with Christmas dinner was brought to her she remarked: "Why don't you let me drink out of a glass instead of a tin cup on a day like this, Christmas morning?" The nurse consented to this and afterwards thoughtlessly left the glass standing in the window. When the nurse returned she found a trace of blood on the pillow, which led to the finding of pieces of the tumbler in the bed, and a cut on the patient's lower lip. The patient admitted that she had swallowed the glass. She said she had felt no pain, either in her lip or in her throat when she swallowed the glass, and did not remember how many pieces she had swallowed. She in fact had very little recollection afterwards of the whole occurrence. No appreciable contraction of ocular fields was ascertainable at this time, and the skin sensation revealed no anæsthetic areas. During the following week, from December 25 to January 1, 1915, she passed 23 pieces of glass and one button, some of the pieces of glass being extremely sharp and pointed, and measuring about an inch in length. She had not suffered from any abdominal pain whatever.

Case III.—F. R.—Admitted November, 1914, white, male, age 32, single, dairyman.

F. H.—Mother considered insane on religious subjects; never committed. Half-sister and paternal grandfather committed suicide.

P. H.—As a boy received injury to left testicle; later, but while still young (exact age not known), performed castration upon himself. Otherwise had been considered strong and healthy, but somewhat queer.

P. I.—Began October 25, 1914, about three weeks previous to admission; in a private institution where he acted and talked irrationally, heard voices and laughed immoderately.

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On admission, physical examination negative, except for left-sided castration.

Neurological examination negative.

Mental Examination: Patient was quite nervous but not apprehensive; was elated at times and at other times "got lonesome." His intelligence seemed fairly good, no apparent disturbance of idea-association; thoughts seemed to pass through the patient's mind more rapidly than formerly.

Five years ago he felt that he had been hypnotized and that thoughts were at times transmitted to him, which he believed he must obey. There were no visual or auditory hallucinations. Ever since that time he has felt that his fellow workmen have attempted to make him too conspicuous in the eyes of his employers and that sometimes his employers have become jealous of him because he might be attempting to take their job away from them.

On admission the patient was quite apathetic, and on the second day began to sing; and later, while in the ward, stated that a thought came to him to commit an immoral act on a fellow patient, which he did. Says that he knew the person who gave the command but that no words were spoken between them, and neither did he see the individual.

The patient had no disease insight, but thought that he had more affection for his family than formerly.

Laboratory report was a triple negative Wassermann; urinalysis, negative.

About the beginning of the year 1916 the patient began to show extreme restlessness and at times such violence that restraint became necessary. During such periods he would mutter to himself, sing aloud, curse, and often pound himself, and batter his head against the walls. He occasionally said that he received wireless messages from the officials asking him to settle his board bills. Mental deterioration has of late become more and more marked.

On May 28, 1916, a teaspoon was missed in his ward and when he was asked about it finally admitted he had swallowed it, and also admitted a few days afterwards, when a number of links in the iron bed springs of several bedsteads had been found missing, that he had swallowed them. At first his statements were not believed, as palpation of the stomach gave negative results, and as he was entirely without pain or distress of any kind, but an X-ray examination, on May 29, showed the presence of the teaspoon in the left epigastrium and five or six bed-spring links in the region of the cœcum.

On June 1, 1916, an operation by Dr. Matthews was made. The spoon was removed from the stomach and six bed-spring wires were with difficulty taken out of the cœcum. Recovery was rapid and uneventful.

The patient was quiet for a time after the operation, but he soon became restless and noisy as before. On some days mutism was present; on other days he would answer when questions were put to him, usually, however, giving random replies with verbigerations, his sentences at times showing speech incoördination and silly, disordered syntax, viz.: "I do not wish

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to die and I am not to die. I am not worthy of anything" (repeating this with a half-smiling face). "There is no land like our land. We are the native sons of this land. This is the greatest land. We know it is all true—this is all true. The truth shall make you free. It may be all so. I don't know it may be all so. It isn't anything that is so. It is all that ain't so," *ad infinitum*.

The patient seemed perfectly well, physically, after the operation, but when a second X-ray examination was afterwards made the plate showed the presence of two more links in the bowels, probably in the sigmoid.

CASE IV.—A. S., Finn, age 34, married, tailor. Admitted October, 1914.

F. H.—Negative.

P. H.—Quiet and industrious; not epileptic; alcohol and tobacco in moderation. Was in Manhattan State Hospital, New York, three or four months in the early part of 1914. History of present illness unknown.

Physical and neurological examination: Inequality of pupils present (r. > l.). Slight deviation of tongue to right. Slight speech defect; left patellar reflex more lively than right. Very slight tremor of extended hands. Otherwise well developed and fairly well nourished.

Mental examination: Patient did fairly well on general survey, but did not know the name of the hospital. There was no evidence of illusions or hallucinations. He was depressed when examined; did pretty well on intelligence tests and memory of recent past, but performed test of recording faculty with some difficulty, but correctly; likewise the word-pairing test and the knowledge of the abstract, but failed on the combined idea-association and Ebbinghaus' test. There was no disturbance of idea-association. He was oriented and showed normal but slow attention. Bourdon's test was performed correctly. He stated that it was hard for him to think and complained of pain in his forehead. There was no perseveration present and no imperative ideas or obsessions; motor reactions normal; disease insight fair.

During his stay in the hospital he was usually depressed and despondent; as a rule well behaved and fairly industrious; usually slept and ate well. At times he imagined that he heard some one talking about and against him. During such periods he refused to eat and would not stay in bed. Toward the end of his stay he spent considerable time praying. The laboratory reports gave a triple negative Wassermann and negative urinalysis.

About January 23, 1916, he complained of abdominal pain, but palpation was negative in the appendix region and a careful study of the temperature did not point to peritoneal involvement until the morning of January 26, when a laparotomy was performed. He had been asked a few days previously if he had swallowed foreign objects, but denied this absolutely. On opening the abdomen the handles of two teaspoons were found protruding from a perforation of the ileum, about two inches above the ileocæcal opening. The patient died about 11 hours following the operation from shock and general peritonitis. At autopsy no more foreign bodies were found.

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PLATE OF THE 921 FOREIGN OBJECTS REMOVED FROM THE STOMACH IN CASE I.

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PHOTO OF X-RAY PLATE (CASE 1) SHOWING SHADOW IN LEFT EPIGASTRIUM WITH OUTLINES OF SAFETY PINS.

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PHOTO OF X-RAY FINDINGS IN CASE III.

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WHAT PERSONAL ATTENTION MEANS TO THE PATIENT.

By H. J. GAHAGAN, M. D.,
Superintendent Elgin State Hospital, Elgin, Ill.

"What shall we do for that great body of humanity confined in the hospital for the insane, who, if left to themselves without some stimulation and measures to interest them, gradually, but surely, deteriorate until all semblance of human instinct is blotted out and they become mere automatons?" If we are just to the friends of these patients we should at least put forth some endeavor to prevent this condition. The more modern methods of diagnosis through the laboratory stimulates more activity in the treatment of organic brain disease, and while the results have not been brilliant, the outlook presents a more cheery aspect in that ultimately incipient paresis and other luetic conditions will be cured. It is the case of dementia præcox which demands our attention, as this form of mental trouble consists of the predominating type of cases in the hospital for which treatment up to the present time has been negative. The happy, cheerful, mischievous and destructive manic finally recovers. These with allied states, toxic and infective exhaustive cases give us 20 per cent of recoveries so gladly pointed to as evidence that some cases get well. How many times have you been embarrassed by this query on the part of a mother of a bright young man suddenly stricken, "Doctor, what are you doing for my son, do you give him medicine?" What is the answer? "Well, no, madam, you see there is no drug yet discovered for the treatment of insanity. We will interest him by means of occupation, amusement, analyze his complexes, give him hydrotherapy, and exercise in the fresh air. Thus, with proper hygiene, regulation of food and sleep, we hope to remove his false imaginations." But do we accomplish anything? Yes, if we can gain the co-operation of the medical and nursing staff. Too often hospital routine is responsible for neglect on the part of the ward physician to give the close personal attention to the individual case which would be productive of the best

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results. The highest ambition of the staff physician is to classify the case, ignoring the great principle of prompt treatment. Something should be done, as much can be accomplished through personal interest. Do not stack up these cases like so much cord wood, but rather forget the diagnosis, and appeal to the patient in the same manner as you would if you were treating a member of your own family. To get the best results one must spend more time on the wards, and become identified to the patients as their friend. Eliminate their fears and troubles with a cheery smile. Do not evade their requests and entreaties with a short, curt reply, but rather sit down and discuss with them their troubles. The physician who maintains a cheery, breezy manner in going through the wards, encourages here or there when indicated, jokes with those who care for humor, takes interest in this story or that, will find his visit looked forward to, and it is quite helpful to the patient to know that somebody is more than officially interested. Rounds made with the regular machine-like precision, frigidly official, cannot awaken sentiment in the patient. When a duty becomes a routine all human interest ceases—something too that cannot be corrected by rule or order. It is a matter with the officer entirely as to just how much interest he is going to show and how deeply he is going into his work. The lesson of personal interest in the patient was exemplified to me most vividly many years ago during the barbarous restraint days. I was making my first rounds on the wards of the Elgin State Hospital. Standing against the wall of one of the wards was a woman with a sad, appealing countenance, restrained in wristlets. She pleaded with me to take them off. Upon removing the restraint she knelt to the floor, grasped my hands, kissed them and wept tears of joy. Restraint was placed upon this woman because she picked her face and scalp. I spent an hour talking to her and got her story. During the clouded moments after childbirth she seized her child and threw it down the cistern. In her remorse she attempted suicide, and was committed to the asylum and placed in restraint. I transferred this patient to the hospital ward, placed her in bed and with suitable care she recovered in a few weeks. I mention this case as typical of a great number of victims who were submitted to these unnecessary tortures. Although a novice in the work it seemed to me that too little attention was paid to the personal

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interest aspect in treatment. Patients were housed in dark, uninviting halls, devoid of any evidence of home surroundings, and if disturbing at all to the attendants' comfort, they were placed in restraint. This was a quarter of a century ago, and education along lines of greater liberty and freedom to the insane was at a low ebb. My superintendent, Dr. Arthur Loewy, was a man of humane instincts and kindly nature, restraint measures being revolting to him, and were discarded. The dormitory and side room doors were left open, and all restraint apparatus removed from the wards, and used only after a thorough consultation of the entire staff as to the wisdom of its use. Parole privileges were increased, and open wards inaugurated. In reading the literature on restraint and care of the insane one finds that a century ago restraint was not practiced. The cottage system with the garden and home surroundings housed the insane in small communities. Since this period we have built huge structures of many stories, with windows decorated with huge bars, and only recently are we adopting the sensible one-story cottage. To properly inspire a personal interest in the patients, one should first of all promote conditions of home environment. This can be accomplished as rapidly on the wards of the acutely disturbed class as on the front or show wards of the hospital. Only, however, by the persistent co-operation of the nurse. Because of the destructive tendencies of the acute class we have denied them attractive surroundings. This is a mistake, as has been proven at Elgin. The barren hall has been converted into a cheerful living room, by the addition of carpets, rugs, pictures, flowers, lace curtains and easy chairs, with the sunlight streaming in through windows unobstructed by the removal of the hideous bars. Most imperative is the dress of the patient. Pretty patterns with the blending of attractive colors should be selected for the destructive patient instead of the strong dress. The latter has been done away with, as also the strong suit for the men. Parole privileges should be generously granted. With the women the group method is very satisfactory. With four in each group they can amuse themselves in many ways, as in tennis, croquet and on the golf course. Golf as a feature for the amusement and diversion for the inmates was adopted three years ago. A stretch of rolling pasture land was converted into a most attractive nine-hole typical Scotch course.

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Twenty-five hundred patients enjoyed the play last year, while a gallery of several hundred more followed about the course. The violent manic and paretic, with the depressed and agitated, are taken out under the supervision of the ward physician. Exercise in the fresh air combined with the interest manifested in the play and the scenic features detract from the clouding and pressure symptoms, producing both sedative and stimulating effects. These patients only a few years ago were placed in restraint and seclusion, exhausting themselves in their maddened delirium produced by the treatment given them. Special care with the inert, stupid and untidy individual requires a patience rarely found. The individual of this rare make-up must in nature be attractive to the patient. One must be satisfied with small returns, infrequent at first. As an illustration of the results which can be attained I wish to describe several cases who were given this close personal attention by a nurse on the wards of the hospital, who had no definite understanding of dementia præcox, but simply patiently stimulated and encouraged these cases in her own way. If one could find many of her type, the results in these cases would be startling.

Case 1.—A. K., white female, age 23. Entered the hospital October 21, 1914. The father was insane. Shortly before 1912 she changed from a bright, lively girl into a nervous individual. Became sleepless, hysterical, and was finally sent to a private sanitarium. She declined physically and would not eat. Became quite violent and hallucinated, and was sent to a state hospital for treatment. Physically, she presented marked contractures, particularly of the head and neck. There were no neurological findings. She was careless of her appearance and indifferent in manner. Quite untidy, mute and had to be spoon fed. Exhibited many mannerisms and often would laugh to herself. This condition continued until March, 1915. Shortly afterwards, however, she began to improve, became less untidy, began eating and talking, became interested in the ward work as well as in the visits of her family. She was paroled on October 17, 1915, apparently normal. After 18 months she still remains at home.

Case 2.—S. S., white female, age 19. Entered the state hospital April 10, 1914, in very poor physical health. Mute, assumed constrained attitudes, was slow, resistive, hallucinated and untidy. Held saliva in her mouth until it flowed in a stream down her dress. Picked her flesh and ate poorly. Began to improve and with much encouragement was gotten to dress and feed self. Gradually exhibited more pride in her personal appearance and rapidly improved both mentally and physically, and was paroled to her folks on July 24, 1915. Letter received from this patient a short time ago stated that she is enjoying good health and is very thankful to the nurse who assisted her so much to gain her normal state.

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CASE 3.—J. L., white female, age 22. Admitted August 6, 1914. Was quite untidy, restless, mute, destructive, inclined to be noisy at times, assumed constrained attitudes, was impulsive, doing unexpected and inadequate things. This condition continued without much change for several months, when she finally commenced to improve and was paroled on April 7, 1915. Frequent letters from the patient and family during the parole period indicated that the improvement continued and she was discharged recovered at the end of the three-month period. A letter received recently from the patient stated that she is entirely well, and was quite effusive in her thanks for the treatment received.

CASE 4.—F. M., white female, age 23. Entered hospital May 21, 1915. Family history negative. A quiet, intelligent girl. Became religious, impulsive, noisy, quite resistive, careless of personal appearance, assumed constrained attitudes, would not eat nor talk, was quite untidy and a filth eater. Continued in this condition for 14 months. Finally began to improve and was paroled on November 29, 1916, and at the end of the three-month parole period was discharged recovered. Letters received recently from the parents state that this girl is well and has not shown any indications of mental trouble.

The nurse who was responsible for this splendid work had charge of a ward for untidy women. It was marvelous the control she developed with her patients. She was patient, gentle, affectionate and always cheerful. Rarely was there an altercation on the ward in her charge. Her patients enjoyed perfect freedom, without restraint of any kind. The nurse knew no hour of service. When off duty she spent her time on the grounds of the hospital with a group of her patients, entertaining them. She spent her own money freely, buying for them candy, fruit and other luxuries. She took great pleasure in keeping the patients nicely dressed, and appealed to their vanity with decorations of ribbons and lace. The hygiene of her ward was excellent. With the close supervision given her patients they soon ceased to be untidy. At Christmas her ward was the finest decorated of any in the hospital, having spent nights and days of tireless energy in accomplishing this result.

Stimulated by the results obtained by Miss Gross, I decided to start a class for the reawakening of demented cases. The class was placed in charge of Miss May, a teacher by profession, who, inspired by humanitarian motives, entered the service of the hospital as an attendant, and joined our training class. The methods and devices used for the reawakening were:

1. Patients were urged to dress and care for themselves.

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2. Tossing a ball—this was most effective in arousing the stupid ones.

3. Blowing soap bubbles—this afforded them lots of fun.

4. Tearing carpet rags and sewing them.

5. Cutting pictures from catalogues, magazines, etc. Cutting numerous hearts and cupids for St. Valentine's day.

6. Talking to the patients and urging them to talk.

7. Making poster pictures.

8. Story-telling, with the aid of poster pictures illustrating The Pied Piper, The Three Bears, The Old Woman and Her Pig.

9. Spool knitting—very simple and easily learned.

10. Sliding on the ice—groups of three and four were taken, and the sport was much enjoyed.

11. A blackboard was used to write poems and mottoes and having the class read them.

12. Stencils and colored pencils proved interesting.

13. Music—victrolas with lively records.

14. Marching to the music.

15. Dancing participated in frequently, music furnished by a male patient and his fiddle.

16. Candy making—the class learned to make and also eat with a relish.

17. The doll—everybody loved to hold it, dress it and make pretty clothes for it.

18. Fancy work—outlining embroidery, hemstitching and drawn-work.

This is a résumé of the excellent efforts put forth for the stimulation of these patients. An article from the pen of Miss May, fully describing the work done, with a history of each patient, is submitted with the exhibit of their handiwork at this meeting. When one contemplates that this class of patients three months ago had no initiative, most of them mute, resistive and stupid, it is certainly amazing to see the beautiful art work from their hands. There has been an entire transformation in the mental picture of each. I am convinced that much can be accomplished through personal attention in the treatment of the insane.

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DIETETIC FACTORS IN PSYCHIATRY.

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Introduction.

The sensitiveness of the cerebral mechanism to chemical disturbance is familiar to every one who has seen the immediate effects of anæsthetics, of morphine, of alcohol. Its sensitiveness to bacterial poisons is familiar in the delirium of the infectious diseases. These are both acute situations and easily observed. The errors of metabolism which disturb brain chemistry are more insidious and produce less marked effects which are less easy to connect with the causative agent. Hence it is only since the recent arousal of interest in the pathological chemistry of internal medicine that much attention is being given to them.

Among these disturbances, those created by improper diet seem to the writer of great importance. The investigation of the subject clinically is rendered difficult by the quality of idiosyncrasy; for the old saw "One man's meat is another man's poison" is nowhere more applicable than where the nervous system is concerned. For instance: A sympatheticotonic person is rapidly poisoned by a small dose of belladonna, from which a vagotonic person derives a state of well-being; a bilioneurotic temperament is thrown into a state of inappetence and depression by a dose of alcohol which renders a sanguine or lymphatic temperament merely expansive for a short while; a tachycardia and tremor may be induced in a person of neurotic type by a quantity of tea or coffee which will cause a loosening of thought and a sense of well-being in the pure lymphatic; the differences in susceptibility to anæsthetics are well known to every surgeon. Pharmacological instances might be adduced in great number. Regarding foods, the same principle seems to play a part, in accordance with the

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metabolic capacities of each person. Some of these we can even now relate to particular functions of the body. For instance: The extreme carbohydrate tolerance of hyperpituitary persons, the steatorrhea of certain forms of dysthyroidia, and of course the well-known carbohydrate intolerance of pancreatic inadequacy.

Data regarding the effect of particular foods upon the nervous system are still scanty; and it is rather by a collection and analysis of facts bearing upon the problem co-laterally that we shall be able to infer the rôle of diet in psychiatry.

Facts Concerning Growth.

1. That starvation of the embyro or infant retards the growth of the nervous system was proved by H. H. Donaldson (The Growth of the Brain) by feeding experiments on rats. This, of course, consists of the deprivation of adequate protein, for none of the other constituents of food are concerned with protoplasmic growth except in an accessory rôle.

2. Furthermore, particular constituent amino-acids are necessary for growth, as Mendel and Osborne have shown. Thus grains free of tryptophan do not permit animals to grow; hence the need of supplementing an exclusively maize or rice diet in stock feeding. The meaning of this is that for the building up, or the rebuilding from waste, of the protein molecule it is necessary to have each constituent amino-acid in the food.

That deficiency of some of these must lead to cerebral inanition and consequent mental inadequacy is to be inferred. That this consequence is not frequently remarked may be due to such facts as: First, a tremendous reserve of cerebrum, it seldom being required the output of energy of which it is capable; second, that this requirement is most often demanded of persons whose diet is not deficient in variety of protein; third, the instinct which seeks rest when exertion is demanded under improper conditions. This is well observed in underfed school children who are inattentive and lazy even when the studies are interesting, such as in play. There is perhaps an exception in the brilliant-minded, poorly nourished child in whom perhaps there is a seizure by the nervous tissues of the available protein, which is thus stolen from the supporting structures, the glands and the muscles. The fourth fact, unfavorable to cerebral depletion, is the very general variety of

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diet which popular custom has sought, so that it is very unusual for people who are not in poverty to suffer from deprivation of adequate varied protein.

Again, the absence of considerable weight loss in the nervous system during starvation must be in part due to a power of seizing upon the amino-acids in the protein molecule in the serum albumen and globulin of the lymph; for it is scarcely to be supposed that neural protoplasm differs from other protoplasms to such a degree as to show no wastage. An additional argument that there is no inherent difference lies in the fact that the heart, too, scarcely loses weight during starvation, and yet there must be considerable wastage during the work of a contractile organ.

1. *Protein Poisoning.*—Most of the substances affecting the cerebrum unfavorably are nitrogenous bodies, and many of them are derivatives of proteins. Furthermore, proteins themselves are so constitued that, until elaborated by the digestive glands, they are powerful poisons. This is particularly so through a slight change of the hydrogen-ion content, as Vaughan has shown.

Furthermore, either alkaliosis or acidosis favors an œdema of the tissues, sometimes so intense as to be discernible by the naked eye or by palpation. A histological œdema must necessarily escape detection (unless it is sufficiently extensive to increase the patient's weight) except by the functional disturbances it induces. It can be attributed to œdema only by inference.

Proteose Intoxication.

That diseased conditions occur because of protein katabolism has been disputed by some clinicians who believe that bacterial toxins are responsible in all cases. This has been definitely disproved by Whipple (J. A. M. A. July 1, 1916, p. 15), who has produced a proteose toxicosis by perfectly sterile intestinal loop occlusions, and also by injecting sterile bile into the pancreatic duct, while he demonstrates a toxic proteose in the sterile peritonitis produced by turpentine, aleuronat and bile. This proteose, especially that caused by acute intestinal obstruction, is accompanied by great increase of the non-coagulable blood nitrogen which may rise to 200 mg. per 100 c. c.

When proteose is injected into a normal dog this blood nitrogen may rise within three or four hours to 60 mg. It has nothing to

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do with renal inadequacy, but must be due to breakdown of the body proteins, as it occurs during starvation and is accompanied by an enormous increase of nitrogen elimination by the kidney, over 100 per cent, which may last even for five days after a single small dose of proteose intravenously. Furthermore, the increase does not begin until the second day. The same effects are produced by closing a loop of intestine or by producing peritonitis, pancreatitis, pleurisy or a sterile abscess. The intravenous experiment proves, however, that the increased nitrogen is not due to what occurs at a site of inflammation, but is a general increase protein katabolism due to the absorption of toxic proteose.

No anaphylactic reactions, precipitines or complement fixations are produced by these proteoses, and so immunity to their action is acquired by the blood; whereas, the tissues of injected animals acquire such immunity, which furthermore can be given by heterogeneous proteose; furthermore a long continued intestinal loop or obstruction permits an animal to survive a lethal dose with few symptoms. The same immunity is induced by a sterile pleurisy or peritonitis.

Pancreatic and tissue ferments and intestinal mucosa do not digest the proteose. This proteose is that which is precipitated by 5 vol. of 95 per cent alcohol or by half saturation of ammonium sulphate. One hundred mg. may kill a 15-pound dog.

Protein Poisoning.

Comparable with the toxicosis of the proteose is that produced by the protein poison of Victor Vaughan (J. A. M. A., November 25, 1916), which is still more lethal; although the symptoms are the same. Both physiologically and chemically these resemble the actions of peptone poison. Vaughan therefore thinks that the body responsible is either identical or closely related in all three. He presents the conclusions of Pryer:

1. All protein contains a poisonous group which is identical or closely similar in action.

2. From 1 mg. of casein enough of this poison can be obtained to kill 800 guinea-pigs when injected intravenously.

3. The protein poison is not beta-imidazolyl-ethylamia or histamin, although the physiologic effects of the two are very similar.

4. The poison is not a cholin derivation.

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5. The poison is a protein cleavage product, acid in reaction, capable of forming compounds and reacting much like the globulins in its behavior to neutral salts.

Levin has shown that the protein poison combined with Witte's peptone, egg white and other proteins, both in vitro and in vivo, and in doing so the action of this poison on animals is modified and partially neutralized.

Cumming and Chambers have found that:

1. The protein poison can be obtained by the method of Vaughan and Wheeler from the tissues and organs of exsanguinated mammals.

2. Poisons thus obtained are toxic, not only for heterologous, but also for homologous, species.

3. All the protein poisons tested inhibit the clotting of blood from the guinea-pig, rabbit and dog when added in vitro in certain percentage.

The findings of Emerson and Chambers are as follows:

1. The proteins and their fragments give the biuret test. The poisons give this test in much higher dilutions than the residues. This indicates that the proteins and their fragments contain acid amid groups and other substituted amid groups and that the products have not been deamideized in the cleavage.

The proteins and their split products give the xanthoprotein test, the poisons in higher dilution than the original proteins and the residues, indicating that all contain benzin nuclei, and in the cleavage these nuclei are concentrated in the poisonous part.

The original proteins and the poisonous fragments give the Millon test, the latter in higher dilutions than the former, while the residues do not give this test, thus indicating that all the monohydroxybenzin nuclei are concentrated in the poisonous protein in the cleavage.

The original proteins and the poisonous fragments give the Bardach test, while the residues do not. According to the accepted idea, this indicates that the residues should not be classed as proteins.

The proteins and the residues give the Molish test, while the poisons do not, indicating that all the carbohydrate group is concentrated in the residue in the cleavage.

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Proteins and both fragments give the Adamkiewicz test, but the color produced with the poisons is uniform whatever the source of the poison and different from that given by the residue. This test is usually considered as indicating the presence of tryptophan, but the shade of color may be influenced by the presence of tyrosin which is concentrated in the poisonous protein.

In a second communication, Emerson and Chambers report on the relative responses of the proteins and the split products to the nimhydrin test. Their conclusions are as follows:

The proteins respond to this test in dilutions up to 1 : 10,000. The poisons are equally responsive to the test. The residues fail in dilutions of 1 : 100.

It has been found that when a drop of an aqueous solution of the protein poison is placed on the skin and scratched in with some blunt instrument, a well-marked local reaction develops within a few minutes. Local tumefaction, accompanied by itching, results. The possible relation of this to the hives and to the urticaria of serum disease suggests itself. Compare Eustis's well-known experiment in which he incriminates histamin.

We find also that the substances resembling the protein poisons can be extracted from normal tissues. The resemblance of these bodies to the protein poisons is both chemical and physiologic. They have been obtained from brain, heart, lungs, spleen, liver, stomach and intestinal walls, kidneys, and most abundantly from the voluntary muscle. In small doses they cause typical anaphylactic shock and death, with the usual postmortem findings. Should it prove that such bodies are normal metabolic products, the protein poisons will become more interesting.

Vaughan considers that the protein molecule is a salt of base and acid, the acid being the toxin. It is in this way he explains the antagonistic effect of calcium in protein poisoning.

The application of this explanation to Fischer's work on acidosis might be fruitful. That nephritis may be due to protein toxicosis of the renal epithelium, Longcope's work indicates. That these may be food products rather than bacterial toxins is believed by Vaughan. It is also believed by him and others that foreign proteins are eliminated into the alimentary canal and may there produce ulceration. The old observation that duodenal ulcer occurs after burns, as well as after application of arsenic to an abraded surface is most significant.

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The toxic substance of the protein seems to be masked by the rest of it. These toxic substances can be separated even in the test tube, as Vaughan has shown. It does not seem to be the toxic substance which produces antibodies. So far they are only produced by unsplit protein. Efforts are being made to produce antigen without toxic consequences. Gay has found that the leaching of a poisonous substance out of typhoid bacilli leaves a residue with greater immunizing power than the whole substance.

Part of the immunizing power of organ power is seated in the products of internal secretion. For instance: Thyroidectomized dogs will die in convulsions in a few hours after being fed on flesh, while they will live for weeks on bread and milk. The explanation that hyperthyroidism is in reality a conservative reaction against protein intoxication, whether bacillary or not, is a contention to be thought of in the adjudication of its etiology.

It has long been known that the liver prevents protein poison. The symptoms brought on when the liver is shut out can be relieved by calcium, which can even prevent the convulsions which occur when meat is fed to such dogs. In this report the condition resembles parathyroid tetany. The vagotonia of this condition is of the same order as the syndrome of anaphylaxis. Nausea, incontinence of fæces and urine, bronchial spasm with urticaria and low blood-pressure are all pneumogastric symptoms.

Sensitivation is perhaps due to a sudden setting free of toxic substance through the splitting of the foreign protein by an immunizing enzym whether innate or acquired. The result is the toxicosis known clinically as the positive reaction. These are sympatheticotonic signs for the most part—tachycardia, fever, chill, gastrointestinal inhibition, dilated pupil and nervous excitement.

The dependence of resistance to infection upon the quality of the food has received the empirical belief of clinicians for centuries, and in our own day, more especially regarding tuberculosis, the importance of a high protein dietary has been emphasized. It was not until recently, however, that any suspicion regarding a specific substance was aroused where, in a study of the climatic factors in the cure of tuberculosis, the production of immunity was concerned. In 1903 the writer presented arguments to show the relationship of immunizing or antibacterial organismal potency to the assimilability of proteins. (Amer. Medicine, 1903.)

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Recent work seems to show, however, that concerning antigen the source may be specific; for in experimental anaphylaxis, nucleoprotein B, *i. e.*, that extracted with boiling water, has an efficaciousness not present in simple proteins or nucleoprotein A. (J. Biolog. Chem., December, 1916.)

Nucleoprotein B is abundant, however, in all the common cereals. It is possibly the antineuritic substance in the pericarp which prevents and cures beriberi.

The researches of H. H. McGregor show that in the central nervous system occurs an extremely labile protein, very sensitive to slight changes in acidity or alkalinity. This may be the nucleoprotein found in McGregor's research. This substance contains iron. It is only one of the individual proteins which were found by W. Koch, the others being neurokeratin and various individual proteins. Of the latter, there is one soluble in distilled water, precipitated progressively by increasing concentration of sodium sulphate and fractionally by heat, it is very unstable, breaking down in weak acids into at least three products varying with the acidity and the medium. It contains about .11 per cent of phosphorus; it gives a slight reaction to the tests for iron; it is about 5 per cent of the dry brain.

The protein soluble in dilute alkali is present in the amount of 10 per cent; it contains .6 per cent of phosphorus; its precipitate is unchanged by acid; it also contains iron.

McGregor believes that the central nervous system contains neither Halliburton's globulin nor A. Maris's acid meta-protein. (J. Biolog. Chem., 1913.)

The Vitamines.

Some clinicians, the writer among the number, have insisted upon the importance of the pericarp of grain for neurological health and have deplored the sophistication of the bread foods of civilization by milling. The experimental induction of beriberi by polished rice and the removal of the disease when the pericarp also is fed is now classical.

The popular mind has not, however, grasped the fact that the same is true of other grains. The experiments of Weil and Mouriquant found the same results from pearl barley, decorticated wheat, and even when those grains were blended with polished

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rice. They believe that the vitamine is contained in the double layer of large cells of areolar protoplasm in the cellulose husk. It is from this that the crystallizable base (C. 17 H. H29 N. 2 O. 7) is derived. In this case the nitrogen is not in the amine form, but occurs as NH. CO. NH. radical, as found in the disintregating nucleus known as purins. Hence the consequences of vitamine starvation may be the result of hypometabolism of the nucleus, affecting in its turn the cellular protoplasm which depends upon nuclear changes as embryological studies have long taught us.

It must be remembered that a very small amount of vitamines suffice to prevent deterioration, a few milligrams sufficing to cure experimental animals which were on the point of dying. It was believed also that Funk's case was concerned only with polyneuritic beriberi and does not cure œdematous beriberi, which was thought to be cured or prevented only when there was given the portion of rice polish which remained in the filtrate, after the Funk vitamine had been precipitated with phosphotungstic acid. This is doubtful (Voeglein).

Not so well known is the fact that even an exclusive flesh diet with all its variety of amino-acids fails to procure adequate development, the thyroid gland in particular becoming hypoplastic; whereas, upon a diet of oatmeal alone the thyroid gland develops freely and the animals are far superior, both in growth and capability, to those fed on flesh alone. (Chalmers-Watson).

The recent experimental work concerning pellagra, where the disease was produced by B. Goldberger by a diet poor in protein and patients restored to health by a diet of high protein content and high variety, has not been interpreted with due regard to the rôle of the vitamines. For the peas and beans which formed a part of the prophylactic curative diet are particularly rich in these substances. It will be interesting to see the effects of the addition to a pellagra inducing diet of a proper amount of vitamines without the excess of protein believed by some to account for the results. Indeed, Jenner Wood's experiments with rats tend to show that this is the case and the feeding of pellagrins with corn chops by him and others and with beans by many Southern clinicians confirm this theory of the disease.

Of course, conclusions must not neglect the fact that the reduction of protein in the course of pellagra needs for its restoration an

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excess of protein as compared with the standard diet of persons in health, just as was the case after typhoid fever before it was the custom to adequately feed patients during that disease. Or as holds concerning a chronic wasting disease like tuberculosis, where the increased breakdown of tissue has to be compensated by additional protein pabulum; not to speak of the possible need for nitrogenous substances to increase the chemical agencie comprised in body resistance and antibacterial power.

As the deficiency of vitamines is capable of inducing an actual alteration of structure in the nervous system reaching the degree of demonstrable atrophy, the inference is legitimate that there must be early stages of this process and minor degrees of hypovitaminosis where functional disturbances alone are manifest.

The fact that the incubational period for beriberi is always over two months and averages over four months after the disease-producing diet is begun is a strong presumption that *formes frustes* of vitamine starvation must occur, and an additional corroborative fact is that the infants of beriberi mothers themselves also show symptoms of the disease and polyneuritis is found postmortem; and that these infants rapidly improve when rice polishings are given.

A further fact regarding the food of many people is the recent extensive utilization of preserved substances which are sterilized and cooked by a high degree of heat in canning; for as Funk showed, a temperature of 130 C. in an alkaline medium destroys the vitamine where beriberi is concerned.

Furthermore the very individuals who are compelled to have recourse to canned foods are those who have scanty access to milk and butter, which are rich in vitamine. It will be remembered that the growth of rats which had ceased when the diet fat consisted of lard was rapidly resumed when butter fat was again fed instead.

But even when a subject is fed amino-acids of sufficient quantity and kind, even when the character of the inorganic moiety of the food is adequate, and even when the water-soluble B is given, nutrition suffers; for animals so fed cannot raise their young to the weaning point. It is necessary to add a fat soluble unidentified substance found in the butter oil (Mandel and Osborne) and in certain vegetable or some animal oil (McCollum), although it has yet to be worked out how many of these do not supply it.

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It has not yet been worked out whether malnutrition of rats when fed on fresh meat (found by Chalmers-Watson, Brit. Med. Jour., 1906) was due to an excess of protein with or without acidosis or whether it was due to deficiency of some vitamine or of substance A or substance B. The fact that rats did a great deal better exclusively on oatmeal is at variance with recent work with American oats, which seem experimentally to be even inferior to either wheat or maize when fed either alone or along with cassin (McCollum). But that this may not be due to a chemical inferiority is indicated by a fact that the oat when supplemented with gelatine instead of cassin gives much better growth. McCollum's explanation is that the constipation which occurs in oat feeding with or without cassin, due to pasty fæces, may induce putrefaction in the intestine, thus adding to the malnutrition.

In the case of maize alone, in order to accomplish adequate nutrition there must be added other proteins to supplement the deficiency of lysin and tryptophan, as well as butter fat and mineral salts.

In consideration of these facts there must be many persons in whom an inadequate ingestion of vitamine-containing foods give rise to cerebral insufficiencies. These must express themselves either as irritable weakness (a lack of mental stamine, as peculiar trends of thought due to a general affective discomfort which discolors one's circumstances) or to actual focalizing of disease on account of relatively poorer resistance of certain regions, on account of abiotrophy or local disease of other kind. Such disorders may manifest themselves in the form of pains, fleeting during the periods of betterment and recurring when a vitaminosis is more marked, or when toxic factors add their weight to a tissue already on the verge of physiological bankruptcy. The above induction may seem highly hypothetical and perhaps fanciful; but it is written deliberately in the hope that clinical experiment may either refute or verify what seems to the writer a valid induction. That the clinical demonstration is lacking need not be presumptive of invalidity; for such reactions are fleeting in kind, complex in causation, and often of long duration in the life of the patient, so much so that they may fail to be regarded as pathological.

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Acidosis and the Brain.

It must be remembered that acidosis occurs in starvation by the breakdown of the body protein and lipoids. Hence, the calorie intake must be kept up. In the diet there should preponderate carbohydrates for heat-forming purposes, and rich by basic substances to antagonize the acid formed by the proteins. These are found in fruits containing citrates, malates, etc., and in vegetables, which usually contain large amounts of alkaline earths as well as alkalies proper.

It is very important to keep in mind that not all vegetable-acid salts leave an alkaline residue in the blood through oxidation of the acid component. This is only so concerning such salts as those of citric and malic acid. Where tartaric acid, in which grapes and unripe fruits are rich, is concerned, oxidation does not occur; and the ingestion is excreted as such, remaining acid while in the body. Indeed, deleterious effects on the kidney have been reported from feeding tartrates. To these calcium is an antidote as it prevents the toxic effects of the acid-producing oat—which is dependent upon tartrate of magnesia.

When acidosis is severe mouth ingestion must be supplemented by intrarectal or even intravenous introduction. The latter is preferable to begin with, when there has been long starvation or vomiting. Pure and sterilized dextrose should be slowly injected into a vein in a concentrated solution of 45 per cent in sterile distilled water. Not less than 30 minutes should be taken to inject 100 c. c.; otherwise, the dextrose will be excreted renally before oxidation.

When necessary alkali should be injected also. In urgent cases the intravenous route should be used, but rapid absorption is possible per rectum. Fischer recommends for either route a solution of the following composition: Sodium chloride 14 grams, sodium carbonate ($NA_2\ CO_3.\ 10H_2O$) 10 grams, distilled water up to 1000 c. c. It should be introduced slowly into the vein or by the drip method per rectum.

It is instructive to study a case of mild and unsuspected acidosis which caused such intense mental disturbance that the patient, a large rugged doctor who stated that he did not know the meaning of nerves and had no sympathy with "neurotic" patients, believed that he was losing his mind. An improper post-operative diet

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had caused the condition, which was quickly removed when carbohydrates were given.

THE PSYCHASTHENIC STATE FROM ACIDOSIS.—A Washington physician was referred by his medical attendants because after an appendectomy he manifested persistent anxiety as to his recovery, and could not be disabused of the conviction that his renal functions were impaired, that cardiovascular disease was impending and finally that he was losing his mind and that he would be permanently incapacitated for carrying on his work. His physician regarded his state as hysterical, and had tried to change his mental attitude by chaffing him and endeavoring to cheer him up, but their efforts were unavailing; so after two weeks I was asked to see him.

I found him anxious and agitated and yet rather ashamed of his emotional weakness, which he tried to laugh away, without, however, attempting to minimize how dreadful he felt. He had scarcely slept for several nights. His pulse rate, which had once descended to 82, had remounted to over 100, and the respirations were 22, sometimes being as high as 26 per minute. Blood-pressure 190.

There was no infection to account for his condition; as the wound had healed promptly, except for one small stitch abscess, and the rise of temperature was inconsiderable, as it had steadily fallen since the operation from 102° to 98.8°. There was restlessness, throbbing around the heart, lightness of the head, marked insomnia and nausea.

I considered that nothing indicated the case to be psychogenetic and that a physical cause must be sought.

As nothing objective except tachycardia and high blood-pressure and neutral irritability were apparent, and as there was no indication of hyperthyroidism, and the blood-pressure had not previously been elevated, I sought for the causes in the post-operative and pre-operative conditions.

All of these conditions perturb metabolism, cause toxicosis and predispose to an acid state. The acid state interferes with cellular metabolism and may even cause cloudy swelling. The functions of the noble elements are impaired; thus muscles, glands and central nervous system are in disorder.

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I suspected that we were dealing with an acidosis, in spite of the absence of acid bodies in the urine. To confirm this inference the alveolar air carbon dioxide tension was measured. It was found distinctly subnormal, being only 28.4 mil. mercury. No other tests were made in this mild case, but treatment was instituted forthwith.

Therapeutics consisted of carbohydrate diet, cornstarch drink during the night, sugar water, puffed rice, and later oatmeal for breakfast, with abundance of vegetables and fruit at mid-day as well as the general diet of the hospital. Thirty grams of sodium bicarbonate was also given every four hours.

As a result the patient was improved within two days and within a week was no longer upset by fears and went to Atlantic City, whence he returned completely well in 10 days.

The carbon dioxide tension in five days had risen to 32.9.

ALKALINOSIS.—The condition of the nervous system found in tetany, although it is known to occur upon deprivation of the parathyroid gland, has not received adequate explanation. McCollum and Voeglin's investigation of the calcium deficiency have received such attention, but a recent remarkable study of Wilson, Sterns and Janney (J. Biolog. Chem., 1915, p. 70) shows that the symptoms of experimental tetany in dogs are enormously relieved by injections of mineral acids. These experimenters infer the possibility that tetany may be due to a hyperalkinosis.

Regarding this, the observations of Bryant should be considered. He has attempted to show that human beings may be divided into two chemical types, herbivora and carnivora. The relations of these with the power of dealing with acid-forming substances or alkaline bases have to be worked out. It is significant that when very large ratios of precipitated milk salines, which are not rich in alkaline bases, were added to a standardized diet of rats that the effects upon both growth and reproduction were bad, and that, even when there were young, convulsions and early death occurred.

CLINICAL.

AS TO DIFFERENT FORMS OF INSANITY IN RELATION TO DIET.

We have far passed in clinical medicine the stage where we are content with a descriptive name for a series of symptoms. This no longer satisfies a physician. We are not content until we inter-

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pret the *rationale* of the syndrome and trace out the process responsible for each symptom, reaching if possible the ultimate cause; for we realize that only in this way can remedial measures be most efficaciously applied.

It is of course now well recognized that insanity is a mere term of sociological convenience, and not a disease of single causation. Hence there can be no single treatment of a person *qua* insane.

Not even for any of the very various manifestations shown by patients of unsound mind can there be a single treatment. For instance, of mania there are many types and different causes; thus maniacal behavior occurs in alcoholic hallucinosis, in typhoid delirium, in circular and periodic psychosis, in paretic dementia, in catatonic excitement and in paranoid conditions. These states are pathologically different, and for the most part must be reached by a different therapeutic, again, what the older writers called melancholia shows itself in chronic alcoholism, in the result of some infections, in the depressed phase of periodic and circular psychosis, in katatonic depression, in certain phases of paretic dementia and in the constitutional psychoses under provocation. And yet no single agency is responsible for the melancholia, and no single treatment applicable. So, of any of the symptoms indicating disorder of the mind, all need interpretations in terms of their pathogenesis before treatment is instituted. This is simply the method of all clinical medicine, which no longer talks of the treatment of heart disease, of albuminuria, of catarrh, of rheumatism, but finds out the process which is occurring and endeavors to meet that, if it cannot find and eliminate the cause.

Hence, in this article the obsolete classification of the insanities into mania, melancholia, primary and secondary dementia, and hallucinosis and delusional insanity will be ignored. Attention will be confined to the physiopathological states where the metabolism is concerned, in so far as dietetic factors are of importance.

Confusional States.

Ever since Chaslin, clinicians have recognized a vast group of mental derangements, of which the central feature was confusion. They have recognized too that a toxicosis is responsible for the symptoms, even when these are of an active type and show themselves as excitement and hallucination, for beneath them all is the

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same kind of impairment of mental function which produces stupor when extreme.

The syndrome is best known in delirium tremens and in febrile delirium; for in each of these it is readily seen that a single pathogen is responsible for varied symptoms.

It has not been so evident that disturbances of the metabolism themselves may produce confusion of mind, but the experimental work concerning beriberi and pellagra point in that direction.

Short of these extreme cases, there is perhaps not yet clinical proof that dietetic disturbances cause grave impairment of mental efficiency; but that mild degrees of mental disturbances are dietetically determined there is strong presumption. The thesis, however, cannot as yet be completely stated; and I can only therefore subjoin a number of instances where the dietetic factor seemed to be the paramount one in the induction of such disturbances as confusion, epilepsy, melancholia, psychasthenia and mania.

The Periodic Depressions and Excitements, Cyclothymic and Manic-Depressive Psychosis.

The lack of more extensive data regarding the dietetic factor in these cases is regrettable. For the rôle of diet as the exciting cause and the means of cure in the subjoined case is most impressive.

Recurrent Mania from Gluttony.—The wife of a clergymen was seen at the York Retreat during my residence there in 1907. For several years she had recurrent attacks of excitement with rise of temperature, rapid pulse, disorderly acts, filthy ways, obscene language. These would occur at the menstrual period, but only every other month, and sometimes less frequently. Preceding and during the attack the leukocytes in the blood were greatly increased. On one occasion 37,000 to the cubic millimeter were found. During the subsidence of the attack, in about 10 days, the count would be normal. Between the attacks the patient might be regarded as normal, although her disposition was somewhat selfish and unreliable. No cause for her attacks had been discovered. The patient had been, two years before, placed upon a strictly vegetarian diet without any benefit, for the principles embodied in this article had not been duly considered in the prescription of the diet.

In the search for a cause, I one day minutely questioned a nurse concerning the habits of this patient, who, on account of the freedom given her between attacks, was not under continuous observation by anyone. I was told that she spent her afternoons in passing from one pavilion to another, taking tea in rotation with the nurses. On each occasion she

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would eat abundantly of what was on the table, and this would go on most of the afternoon. Moreover, she would spend all her money on sweetmeats, and often more substantial things, which she would eat during the morning, seldom offering any to another person.

From these data I theorized that her maniacal attacks were the expression of the outburst of accumulated toxicosis, due to her gluttonous habits. They were precipitated by the toxic wave of the menstrual period, but they did not occur every month, because during the maniacal attacks the patient was practically starved, and insufficient time elapsed before the next menstruation to allow of sufficient accumulation to produce toxicosis.

Whether these were secondary effects of bacterial action, the defence against which was broken down by the excess of food, or whether they were purely biochemical in mechanism, we did not determine, for we were primarily concerned with practical therapeutics.

It was formerly thought the leukocytes indicated bacterial invasion, but experiments prove that it is an indication merely of protein intoxication for a leukocytosis as high as 40,000 may be induced by the injection of nucleins as well as by various bacterial toxins without the introduction of live organisms at all.

The result fulfilled the expectations of the theory, for the patient's indulgence was prevented, the attacks ceased, she returned home, and my latest advice was that she remained well some years after.

MARKED CONFUSION DUE TO METABOLIC MIGRAINE RESEMBLING PETIT MAL.—A bacteriologist, aged 30, was referred to the writer in the spring of 1912, by Dr. Paul Johnston, because of attacks he called "bilious" (but not preceded or accompanied by constipation), which produced headache, preceded by numbness and pricking in the fingers, followed by dizziness, mental confusion, and foolish talk of paraphasic type, without loss of consciousness. These attacks had occurred every two or three months since the age of 22; they were of very short duration; there were no scotomata, but they were formerly accompanied by vomiting. The headache was of the splitting kind, lasted all day, and was followed by dulness and slowness of thought the day following. The capacity to concentrate his thoughts was increasingly impaired even between the attacks. He was at times irritable. He had no bad habits, and, apart from these attacks, he was well and strong. He received a blow on the left side of the head as a boy, and there was still a dent in the left parietal region, upon which side the headache more often occurred. He had a large appetite, which he said he controlled, but he ate meat thrice a day, although, he said, sparingly. The blood-pressure was not raised, and reflexes and sensibility were normal.

Treatment and Progress.—He was given the low protein "standard" diet. He wrote the writer the following winter: "Since I have reduced the amount of protein in my diet and increased the quantity of vegetables, I have had no recurrence of those spells." Dr. Johnston informed the writer that he remained well to date, over three years later.

CONFUSION, VERTIGO, HYPERTENSION.—A Congressman, aged 57, was referred, March 19, 1912, to me by a well-known Washington physician. His

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complaint was dizziness, trembling on walking and torpor confusion. However, these symptoms had first occurred on his graduation, and again 15 years before I saw him. On each occasion he recovered by means of physical labor on a farm. They have occurred from time to time since. Being advised that they might be due to an error of refraction, he saw Dr. Wilmer, who gave him prism exercises, without benefit. The vertigo so alarmed him that latterly he never went out unaccompanied.

Intercostal neuralgia had troubled him, especially when tired; and troublesome constipation caused him to take purgatives daily. The physician who sent him to me had recommended a course of baths, but these did not remove the symptoms, which, however, were always relieved by a hot bath and by whiskey. He was a very hearty eater and an excessive smoker.

Examination showed only some exaggeration of the deep reflexes, failure of the right plantar, abdominal and cremasteric cutaneous reflexes. The motility was normal, except for a slight lack of firmness in the gait. Sensibility was normal, and the pupils reacted and converged well. The heart sounds were clear, the second being somewhat accentuated. The systolic blood-pressure, which a year before had been 190, had been reduced, under the care of the physician who referred him, to 160 when I examined him. He exuded an unpleasant odor of sour tobacco. Psychically he felt dull, as a rule, falling into a dull sleep readily, but worried much and felt very restless at times, especially after exertion.

The diagnosis was toxicotic hypertension. The prognosis was good. The treatment consisted of the limitation of tobacco to three cigars a day, cure of the constipation by special diet, removal of the toxic condition by this special diet aided by a course of baths to favor cutaneous action, and exercise in moderation to increase metabolism.

As a result, by April 18 the systolic blood-pressure was 130, and he was rarely dizzy. A favorable result, however, caused him to exceed dietetically once or twice, so by April 25 several dizzy attacks had occurred. The blood-pressure, however, was only 124 the day I saw him. The instructions were emphasized, so that by June 2, with blood-pressure 122, there had been no vertigo. On June 23, blood-pressure 124, constipation induced vertigo again; and it occurred once more on July 11 as a result of oversmoking (blood-pressure was only 120 when I saw him).

His complexion had improved, his eyes become clearer, the accentuation of the second cardiac sound had disappeared, and he was able to perform his duties like a normal person. Thanks to an intelligent and earnest wife, who sees to his diet, this patient remains well, May, 1917, even throughout a period when his wife was severely ill.

Epilepsy and Stupor with Organic Changes.—A man of 64 was sent to me by his physician in 1910, because of the recent occurrence of epileptiform convulsions with loss of consciousness.

The first attack had occurred in May, 1909, at an elevation of 12,000 feet, near Durango, while he was inspecting the school buildings there. He was unconscious for half an hour. The second attack occurred shortly

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after, upon leaving the train in Chicago, while making for the staircase. It lasted about an hour. A third attack took place that July in his office, lasting one and a half hours. The fourth, and last, had occurred two nights before his visit to me, while he was visiting a friend and sitting down. It lasted three hours.

The attacks are preceded by a creeping sensation in the left upper arm, passing slowly down to the hand, which becomes numb. In about 15 minutes unconsciousness supervenes. The face is said to be flushed, but he is uncertain whether there are convulsions, though others have told him that there are. The duration of the attacks was only surmised.

Previous History.—Scarlet fever at six, without bad sequelæ. An active living, healthy man, except for two years of asthma, 25 years before, a result of constant attacks of catarrh. It was cured by working as a farm-hand for three weeks. He smokes two cigars and a pipe a day. He took coffee and was a heavy drinker until after the attack, now he has ceased to take even tea. He has always been abstemious in eating, but has been fond of salty foods. He drank "when he felt like it." Since these attacks he has had a pain over the forehead when coryza occurred. As he had read that insanity might come on from this catarrh, he was at first a little anxious about his state, but soon steeled himself against it. The pain in the head was rather a feeling of depression and a grumbling pain, like that of catarrh. The discharge was slight, and the headache disappeared when it ceased. He used to sleep quite well, but about the time of his attacks began waking in the early morning, and could not fall asleep again. This persisted. He had been recommended to eat more and to take fat meat, and this he has done.

Physical Examination.—Reflexes: Knee-kick, R. > L. Achilles reflex, R. > L. Triceps, L. > R. Radials equal, none markedly exaggerated. Plantar reflex is flexor. The left cremaster is absent.

Sensibility.—No abnormality in lower limbs to pain, touch, temperature nor attitudes, though the latter are sometimes wrongly named, but correctly recognized. Arms, perfect localization of light touches both segmentally and axially. Spacing sense of fingers normal. Other modalities normal except sense of attitudes poor, especially in the left hand. No hemiopia or color inversion of visual fields.

Motility.—Normal, but left fingers weaker than right. Diadocokinesis regular. Pupils contract promptly.

Psychic Functions.—He thinks his memory is weakened since the attacks. There are no disorders of speech. Emotionally, he has always been easily excited when there was a cause, and has been accustomed to occasional sadness.

Diagnosis.—The localization of the aura in the left arm and hand, along with the increase of the triceps reflex and the loss of the cremasteric, point to an organic perturbation of the sensorimotor area of the right hemisphere, probably mainly in or near the cortex of the central fissure, opposite the second frontal convolution. The cremaster governing fibers are, of course, attacked in some other situation.

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As neoplasm and granuloma were each unlikely, and as the man's age is that of arteriosclerosis, of the state preceding which recently acquired matutinal insomnia was indicative, I believed it was wise, although lacking proof, to adopt the supposition of sclerogenetic toxicosis, and put it to the experimental proof of therapeutics. Accordingly, a diet light in proteins was ordered, and coffee and tobacco were forbidden. The result was confirmatory, as the patient, one year from the consultation, remains free from attacks and insomnia and is perfectly well, able to perform his very strenuous work, often in high altitudes.

I believe that the first attack was inaugurated in consequence of an ischemia of a part of the right Rolandic region, due to the heart, strained by the high altitude, not being able to keep full of blood a partially sclerosed vessel distributed to that area. The second attack was likewise due to a sudden demand upon the heart upon leaving the train after a very hot journey.

MELANCHOLIA.—The following case, that of a physician of 68 was referred by Dr. A. E. Balloch, after a year's grief and worry. He slept badly, had paræsthesia in his hands, feet and hearing organs. He took narcotics in increasing amounts. He lost weight and power of endurance. His optimism was replaced by dulness or distress, by turns, and he wept much over his griefs. No objective changes of reactions of nervous system were revealed by examination. The tension was 160 mm. But proteosenetic toxicosis was diagnosed from the matutinal nature of the insomnia, the paræsthesia without sensory changes and the loss of endurance. A diet low in proteins and purins led to disappearance of unpleasant symptoms. He remained well three years later.

PSYCHASTHENIA.—An engineer of 38, referred by Dr. Atkinson; powerful, energetic man, formerly accustomed to active work, had been unable to concentrate upon the office work to which he had confined himself for over three months. Previous to this he had been much less active, and latterly he had been very much worried by an official inquiry into a contract for which he had been mainly responsible. For no cause known to him, he is torpid mentally, cannot concentrate, feels a dread in the mornings, and an indecision in business matters is now realized to have been present several months. There was no syphilis, nor any other organic diseases.

He had been improved by three weeks in the woods, during which he was very somnolent, but relapsed at once upon return, and could hardly stand his morning suffering. There was no insomnia.

Physical Examination.—The reflexes were rather active, but there was no other objective change in the lower neurones; there was no amnesia; the sexual hygienic was normal. He was much depressed, and longed to go away from it all for a year, which he could well afford to do.

Treatment.—He was sent for three weeks into the mountains. This time he fully recovered, on account of the light diet which he took. Breakfast and supper were fruit and milk, and his mid-day dinner was vegetables and six ounces of meat; after a few days cereals were added morning and night.

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Carbohydrate and Fat Excess.

It has been claimed that excess of fat may lead to mental disturbances. Mercier has presented a number of cases in support of this, and he believes that F. Hare in "The Food Factor in Disease" has established the connection, more especially where headache and confusion are concerned. Some of the conspicuous symptoms in Mercier's series were a dazed and muddled feeling, confusion of mind, depression, screaming fits and motiveless weeping and laughing, defects of memory and hallucinations of sight and hearing.

It is to be noted that the symptoms due to excess of carbohydrate and fat are worst in the morning and clear up towards evening. Many of his cases improved when butter was restricted and meat increased. I append one of his cases, cured by increasing meat intake.

Widow, aged 70. Pain in the head, giddiness, sleeplessness, shocking dreams. Between sleeping and waking has visions of murdering people. Lives chiefly on milk puddings and a little fish. Meat once a week, fish twice, and but very little of either. Does not get to sleep till between three and four, and sleeps only for two or three hours. Told to eat meat every day, and a large ration. In a week she had increased her sleep to four to five hours. In a fortnight she lost her visions. In three weeks she was sleeping well and did not dream. In four weeks she was sleeping 10 to 12 hours, but still suffered from pain in the head. In seven weeks she lost her headache, slept well, and did not dream. Volunteered that she was better than she had been for three years. (J. Ment. Sci. July, 1913.)

Xanthine Poisoning.—It is, however, to be noted that many of Mercier's cases, which occurred in the English poor attending the dispensary for mental disorders at Charing Cross Hospital, consumed large quantities of tea. Among the poor of England this is taken very strong and stewed for a long time. Consequently its tannin content is very high; hence the proteins of the diet are rendered insoluble. Mercier does not state in his article that he rectified this vice of his patients; but it is not likely that he failed to do so. Perhaps then we may attribute the disappearance of the psychasthenic state of his patients, in part at least, to the diminution of the thein intake, and in part to a better digestion on account of abstention from tannin as well as to the greater assimilability of the proteins in the diet they were taking, in addition to the factor Mercier adduced, viz., the lessening of the fat

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and carbohydrate intake and the increased amount of protein in the form of meat.

THE PURINS.—That xanthine bodies can produce psychasthenic symptoms in certain individuals is well authenticated. I have observed a United States Congressman in whom one cup of strong coffee would produce a state of extreme agitation both mental and physical so that he trembles violently, stammers over his words and cannot think connectedly.

The following case is still more remarkable:

SEVERE PSYCHASTHENIA IN A CHILD AGED TWO YEARS.—A girl. Nursed at the breast until two months old, fed on condensed milk until six months old, fed on cow's milk and water until 18 months old, then allowed to take any food she wished.

Since the age of three months her mother has given her coffee at the same strength as taken by the family, and she now drinks three large cups a day; the rest of her diet consists of one-third of a glass of prepared cereal in the morning, and during the day she nibbles about one slice of bread and butter and eats a small piece of potato at mid-day for dinner. She will eat neither egg, fish nor meat, and she refuses vegetables and fruits.

She, however, since the age of six months, has been fond of eating plaster and earth.

Two months before she was seen she had begun to scratch her wrist during a great part of the day and had produced a deep, raw sore there, which still persists.

For several weeks she has screamed all day long, and seemed in great distress. During the night she wakes suddenly and jumps up, and her sleep is restless and disturbed.

On examination, the fontanels were found open, there was a slight rosary and the radial epiphyses were enlarged. The nutrition was poor; the deep reflexes were exaggerated; the tint was sallow; the intelligence was not accessible at the examination. In spite of her apparent excitement she seemed emotionally indifferent and was not perturbed by the examination. But she screamed at the top of her voice nearly all the time and appeared to be in acute distress. There was no local tenderness to account for this; and both sensibility and motility appeared normal. Dr. Donnally, who was kind enough to let me see the case at the clinic of Dr. Wall, of the Children's Hospital, could find no disease of a medical or surgical nature other than indicated by the symptoms aforementioned. The sphincters were under control.

The psychasthenia of this case was clearly shown since the age of six months. The eating of plaster and earth is the consequence of a psychologic state—the feeling of inadequacy. This results in the desire for a satisfaction to terminate it. Every one must be

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familiar with the feeling which even a superficial self analysis calls " below par." With more or less intelligence the adult adopts the relief of food and drink, tobacco, distraction, excitement and what not. By these means he may abolish, or forget for a time, the feeling, which often passes away of itself in a cyclical manner. But when the longing is the expression of a constant physical dyscrasia, as in the case of this child, it is apt to be more continuous and insistent. This was clearly manifested in her by the erosion of the flesh which she maintained on her wrist. The impulse which determined this will be clearly evidenced by a parallel case quoted by Janet.

The screaming of this child, too, was merely another experience of general discomfort, of psychasthenic depression wearing the guise of excitement. The malnutrition, which prevented closure of the fontanels and produced a physical dyscrasia, was responsible for the psychic state.

There is little doubt that the lack of appetite was a result of the psychasthenic state rather than its cause, and that the latter was in the first place produced by the intoxication of the caffein imbibed constantly since the age of three months.

Again I quote a parallel case of a woman who had been prescribed 3 grains of caffein each day. After eight months of frequent attacks of " angoisse " she gave it up, whereupon the attacks ceased. She, however, resumed the drug and the attacks recurred, and she relapsed again and again until, finally, she ceased the caffein. When one remembers that this is only the quantity contained in one and a half cups of coffee of average size and strength, or in about three cups of tea, a frequent and insidious cause of nervous depression is strikingly revealed.

The experimental work of Kræpelin has shown very clearly the progressive inaccuracy of the motor functions performed by persons under the influence of tea or coffee. The laity do not realize that the cocoa bean also contains an xanthin body, theobromin, so cocoa and chocolate must be incriminated as potentially injurious in this way to certain individuals.

Psychological Factors Concerned in Diet and Eating.

REFUSAL OF FOOD.

Many of the obsessions and little manias of the mentally disturbed are concerned with food. For instance, in mental anorexia

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the psychological incapacity or refusal to eat may be so insistent that the victim may starve to death. This condition is usually regarded as analogous to the stereotyped mannerisms shown in dementia præcox: it is not a common eventuality however.

But even in his extreme anorexia, a patient may for years starve himself so as to become almost a living skeleton. One young woman in Déjèrine's clinic had for months eaten daily only half an egg, one lemon and two biscuits.

The cause of this reluctance to eat is a notion of the patient, usually that eating will keep her normally fleshy. This she objects to on the score that it is a pandering to the body. Of this she is ashamed because it is carnal, and therefore evil: whereas she believes that she should seek to attain the good, which is the spiritual.

In most people with this notion the call of appetite is stronger than principle, and they succumb to the temptation of eating, stilling their conscience by some specious excuse, or becoming convinced of their error and changing their principles.

Indeed, it is by changing the point of view of the patient regarding food and eating that the physician accomplishes the cure of mental anorexia.

Unfortunately it has been the custom when a patient complains of inability to digest certain articles of food, and when the doctor finds no deficiency in gastric secretion and that the contents of the stomach pass through the pylorus without undue delay, that he often resorts to the diagnosis of nervous dyspepsia or indigestion, even although pain and flatulence may be complained of as well.

The notion in the physician's mind is usually very vague, as is shown by the nature of the treatment he gives; for among the drugs exhibited in such cases, the commonest are strychnin, which is given for its supposed action as a nerve tonic; bromides, in order to quiet the nerves; aromatics, especially valerian, which are still more vaguely supposed to influence the nervous system in an "antispasmodic" manner. If the doctor believes himself "more advanced," he may use hydrotherapy in the form of cold douches, believing that in some occult way it will give "tone" to a nervous system with which the doctor confesses himself non-conversant, but which will be restored to efficient action if stirred up by this means. Or if his bent has turned towards psychotherapy, or physiological therapeutics, as it is termed, he may meet

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mystery by mystery by applying electricity to one or more or all parts of his patient, perhaps concealing the empiricism which is his real guide by a number of theories and terms of pretentious and portentous ponderosity.

The survival of such anachronistic absurdities must surely indicate that they possess some merit at least; and this will appear as the pathogenesis of the state benefited is considered. The practical empiricism which leads its adherents to believe the doctrines of each of these various means of therapy has eventuated, in extra-professional circles, in such doctrines as those of Christian Science, healing waters, pools[1] and relics, the efficacy of which is well established in certain cases, although the doctrines on which they generally depend need not here even be discussed, so much at variance are their foundations with all that we know of biology.

In general, one does not hear much of the failures which accrue to each of the foregoing methods of treatment. As a matter of fact, by spending some years in trying one of these means after another, most cases eventually recover, perhaps spontaneously during a period when they are trying no treatment at all "they just got well."

Now, it is inconceivable that a neuronic paralyser, such as the bromides, can by its pharmacological action abolish the same perversion of neutral activities as would be accomplished by strychnin, which on the contrary is a powerful excitant, to the lower neurones at least. Of the anti-spasmodics, the effect is more local and reflex, and is strictly temporary, and, more often than not, entirely without permanent benefit in nervous indigestion, as the histories in a neurologist's case-books clearly show.

Indeed, in many cases, the gamut has been run through drugs, hydrotherapy, electricity, restrictions and modifications of diet, and even change of habits of life and occupation, without any benefit, and indeed with progressive emaciation, asthenia and "nervousness," by which term the patient describes an inadequacy for the manifold reactions required in the adjustment to the innumerable exigencies of daily life, personal, social and professional.

The supposed cause, a direct disorder of the nerves regulating the secretions and movement of the viscera, the sympathetic or

[1] No copy has been received for this and the following references.

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automatic nervous system cannot be incriminated. Though our knowledge of the functions of this system in health and disease is still imperfect, we do know some conditions in which it is perturbed; *e. g.*, the gastric crises in locomotor ataxia are caused by the implication of the sympathetic nerve-fibers in the spinal roots, en route to the rami-communicants.[3] They are not spared by the chronic meningeal inflammation which by compressing the radicular nerves[4] and blocking some of the nerve fibers produces the incapacity to control the muscles which is determined by the failure of nerve impulses to reach the higher nerve centers which regulate movement.

But the gastric "neuroses" present a very different picture to this, and are curable by a very different procedure[4]; for they have nothing to do with the autonomic nervous system, except in so far as they are influenced cerebrospinally in the way demonstrated by Pawlow.[5]

It may be recollected that in dogs he determined at will a flow of gastric and salivary secretions, not only by giving a dog flesh to eat, but first by merely showing the flesh which the dog expected to have, and later by the mere ringing of a bell which the dog learned by previous experience to be a signal for a meal. But not only that, for he could inhibit secretion by inducing fear, as by showing a whip to a dog who had experienced its use.

The *motor efficiency* of the stomach is shown by the experiments of Cannon[6] to be much more easily and gravely impaired by unpleasant emotions than even psychologists had suspected. For instance, peristalsis entirely ceased for 15 minutes after one of his cats had been perturbed, although she showed her agitation only by a slight swishing of the tail and was quietly sitting on Cannon's knee. He also reports the case of a woman who, to the surprise of her physician, showed one hour after a test-meal, not only no digestion and no acid, but remains of the supper of the night before. Suspecting something unusual, the physician fortunately repeated the test the following morning, when abundant acid and good digestion were found. The patient confessed that she had been much agitated on the first night by her husband, who had employed his visit to town in becoming intoxicated.

These facts show the great importance of prescribing test-meals under conditions favorable to good digestion; otherwise

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serious misinterpretations occur as to the patient's digestive power.

Cade and Latarget[7] have performed similar experiments on human beings, but have found contrary to the case of Pawlow's dogs that the withholding of an appetizing morsel does not stimulate a flow of gastric juice, but often arrests it. The principle is not destroyed however, for the arrest in human beings is due to the overpowering of the anticipated pleasure by the irritable temper induced by withholding the morsel. I have noticed subjectively a similar effect from too long waiting between courses when very hungry at dinner.

Cannon used respiratory distress as the inhibitory agent in his experiments, and proved that this acted through the nervous system and not through asphyxia, because it had no effect when both vagus and splanchnics are cut, after which motion too is without effect. When the vagus only is out, the stomach movements can, on the contrary, be impaired emotionally and by checking respiration.

Now, these reactions we call psychic,[8] because they are due, not to a direct stimulus of a simple system of lower neurones, instinct in their disposition, which we call a reflex, but are due to a complicated series of reactions modifiable at will by environment and dependent upon acquired memories of sensory experience, which are associated into what we call ideas. Thus the idea of the approaching meal caused gastric secretion; the idea of the whip caused fear which inhibited gastric secretion.

Now, exactly the same mechanism is at play in human beings, and the number of associational stimuli which they possess is comparably more numerous. Every one know the simple watering of the mouth when palatable food is thought of during hunger. Most people now realize how the appetite fails and even the mouth becomes dry if they attempt to eat during distressing circumstances; but it is not so clearly realized that a *slow* fear, worry, or a spirit of unrest and hurry similarly interferes with digestive secretions by preventing the enjoyment which Pawlow discovered to be the most important essential in starting the flow of digestive fluids.

Food eaten in this way does not agree. An attack of indigestion follows an article of food eaten under unpleasant mental con-

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ditions. An apprehension about this particular article may occur on the next occasion it is partaken of; and this recurring each time inhibits the gastric flow and the article is henceforth tabooed. The same process may be gone through with one kind of food after another.

But a much commoner source of the apprehension is an idea derived from others, that a particular article may disagree. Food faddists are as loquacious as numerous, and a constant bombardment with pessimistic phrases about the indigestibility of anything from bananas to beef will inevitably create in most people a feeling of discomfort when such article is placed before them. Doubt prevents enjoyment, and the juice does not flow.

A still commoner source of pernicious ideas as to one's digestive powers is the medical profession.[9] Every one has indigestion at one time or another; many consult doctors for this; and most patients are suggestible to a certain extent. The authority of the physician makes his words impressive in a way he does not always realize. His conviction expressed, if not by words at least by his giving drugs for the stomach, is a strong reinforcement to the patient's belief that that organ is diseased; and as the drugs he gives tend to modify the gastric secretions, instead of removing, they only perpetuate the gastric discomfort. In fact, the physician's whole attitude is one huge "suggestion" that the stomach is the primary seat of the trouble.

Now the production of a symptom by suggestion, if it is also removable by the same means, brings it within the category of hysteria, as defined by Babinski,[11] and fully explained by the writer.[12] For modern diagnostic acumen has eliminated from the *olla podria* in which was thrown every incomprehensible nervous symptom: (1) Cases of trickery, simulation and mythomania;[13] (2) modifications of the tendon, cutaneous and pupillary reflexes; (3) vasomotor and trophic neuroses,[14] such as erythromelalgia, idiopathic œdema, etc.; (4) other psychoneurotic states, like psychasthenia,[15] the main symptoms of which are the emotional and intellectual besetments so distressing to the patient; (5) true neurasthenia,[16] characterized by great fatigability and due to metabolic intoxication; (6) cenesthopathia,[17] which term designates a state we believe due to perverted sensations from the autonomic nerves in the viscera or their hypothetical centers; (7) mental debility,

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congenital or acquired; (8) the dreamlike states, seen in the early periods of dementia præcox [18] and confusional psychoses, and very often miscalled hysteria on account of the *bizarrerie* of the patients' acts and words; (9) and lastly the emotional perversions of degenerates.

So that we conclude:[19] (1) That all the symptoms which may legitimately be included under hysteria are imposed by suggestion; (2) that the state of suggestibility is derived from (a) the faulty education, tending to perpetuate and fortify the natural suggestibility of the child; (3) cerebral modifications due to organic causes, the action of which necessarily varies among individuals in accordance with (4) the hereditary constitution.

The doctor, then, has created a hysteria taking the form of nervous dyspepsia.

The patient then should be curable by suggestion-persuasion; and this is indeed the case as the following example will show.

In January, 1912, a child aged 11 was referred by Dr. Jung, who had been treating her because of dyspepsia and a capricious appetite. During the preceding three years, she had left school three different times because of her health; the only occasion on which any definite disease had occurred was six weeks before she was sent to me, a slight operation upon an infected corn. After this she had been dieted by Dr. Jung, and seemed to improve for about two weeks; but during the week preceding my consultation, she had lost one and a half pounds.

Anamnesis.—Upon going to bed she feels sick and weak, and pains shoot all through her; she has had a constant headache for several months. When she feels ill, she is very peevish; and she felt homesick for playmates, as she had made no friends in Washington where she had only been a few months. Instead of playing she sat or lay about most of the day feeling too tired to fetch her books for reading, of which she was formerly very fond; she had also been fond of games. She had had glasses since the age of eight, but had not worn them until lately. Her appetite was very poor.

Examination.—Showed rather feeble reflexes; the feet were flat, but not pathologically so. Motility less vigorous than normal, especially in the ankles; unskilful diadocokinesis; a tic of the shoulder and much wriggling; and normal sensibility.

Psychologically, there were no intellectual abnormalities nor marked emotional reactions, except that the little girl wept when it was proposed to take her away from her mother and father to the hospital. The mother had been very conscientious in her upbringing, and this had reacted on the child, before whom far too much attention had been shown regarding both manners and physical welfare. Conversation before her would frequently

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concern the appropriateness of different foods and their digestibility, and the atmosphere of the home was one of solicitude about the child's health.

As an infant, she was not retarded; she had been apt at school, except in writing, when her hand would jerk; but the hands did not do so in sewing, in which she was skillful. Her bad writing in school disturbed her, and she would become "hysterical." Respiratory infections were easy and frequent, as was the case with her father.

Perhaps this was accountable to mouth breathing, for which adenectomy was done when she was eight.

Diagnosis.—As Dr. Jung assured me that the stomach functions were performed quite well and that he could detect no physical disorder of the digestive apparatus, and as the condition for the implantation of an *idée fixé* were apparent; and as conversation with the child herself corroborated my suspicion of this, it was evident that we were dealing with a case of hysterical nosophobia. By this is meant, a fear of disease implanted by suggestions, a matter very easy in young children and uncritical people in general. But it is quite exceptional for food and appetite to be the subject of a phobia in so young a child; for in the child the vegetative functions and instincts are usually paramount. (While in Paris in 1906-1907, I saw one other case of this type of false gastropathy in a young child (published by Déjérine since).)

Treatment.—She was sent to the hospital on account of the nosophobia from which she suffered, the result of too much sympathy at home. When her parents left her, she wept bitterly; but she was soon cured by being made to breathe in quadruples and by a little "jollying." She promised she would try to behave properly if her parents were allowed to visit her. The promise that they might do so stopped the weeping for 24 hours; the visit was postponed however. She was encouraged to play with another little girl patient, and this she came to enjoy so much that she ceased to ask to go home. When she had become quite contented and happy she was allowed to return home, where she has remained well ever since.

The treatment in the hospital consisted of creating an atmosphere round the little patient designed to show her how trivial were her own preoccupations about what she should eat as compared with the real suffering and disabilities of the patients round her in the ward. Of design she was placed in the open ward in preference to a private room. She was shown to what a degree her feelings and behavior were under her own control, and no solicitude was shown about whether her food would agree with her or not.

It is not possible to set down in detail the numerous measures used to destroy the inconvenient suggestions to which she had been subject so long. While the therapeutics inevitably contained a modicum of suggestion, yet the end worked for was always the giving of a rational understanding to the little patient of why her

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symptoms had occurred and how to prevent them in future. In other words, the *modus operandi* was persuasion and re-education. Towards this the hospital furnished a valuable aid, but not merely because it was a hospital, but because the nurses were intelligent coadjutors of the case. The child had been too much derationalized to have been manageable by office consultations alone, unless the mother had been able to collaborate, which she was unable to do, not from lack of intelligence or conscientious desire for the good of her child, but because she had not understood the psychological mechanism of the daughter's illness. The mother's re-education was much more readily effected when uncomplicated by the child's presence. Its success was shown by her successful management of the child when she returned home, for 18 months later there had been no further trouble.

Fads About Food.

Especially in children the occasions for unwise prejudices against or in favor of certain foods are very numerous. They are due to the way of looking at these observed by the child on the part of his elders. Pessimistic feeling is easily engendered by focusing the attention upon the unpleasant feature of any situation. In this way, susceptible individuals are easily incited to more disgust of any object or situation. If the object is food or the appurtenances of feeding, loss of appetite, nausea and arrested digestion will result by the mechanism previously explained.

To deal with such a condition, there are two ways. One is to educate the child in the direction of his not permitting himself to be so suggestible as to allow extraneous considerations to influence his judgment. Another way of obviating the bad consequences of pessimistic surroundings is the looking upon the bright side of each situation, either before hand or as it arises. It is this principle which has been adopted by certain sects who profess to heal disease. It is a principle which has been utilized by moral philosophers too in all ages. Unfortunately, logicalness and respect for the truth are usually absent from the modern exponents of this method, whose wish is too often the sole support of their thought.

It is not by the inculcation of an ill-founded optimism that the psychotherapist of this day seeks to marshal and strengthen the

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psychological forces of his patient. He endeavors to do so by giving his patient the understanding of his own potentialities and deficiencies in order that he may learn managing them skilfully, so as to live wisely according to his capacity. This does not mean that modification of disadvantageous traits is not sought, but only that which a wise psychodiagnostic survey shows to be expedient and possible is attempted, and the wild-goose chase of creating out of a moron a self-sustaining city dweller is seen in the proper perspective as merely a less agressive absurdity than the attempt to make a Newton from an idiot.

This kind of psychotherapy recognizes that just as physical exercise is needed for strong muscles, mental and moral exercise is needed for a strong mind. The child must be taught to weigh and choose even at the expense of mistakes rather than that mistakes should be avoided by confining choice to his guardians.

Morbid Desire for Food.

Complementary to the obsession that food of some particular kind is obnoxious, is the obsession to take food to give strength for some ordeal. This false notion is based upon the truism that energy is derived from food. It is a manifestation of the psychasthenic state, being one of the responses to the feeling of inadequacy which is the hallmark of that disease. The desire to escape this feeling leads to some very peculiar reactions. For instance: One of Janet's patients would pour boiling water on her foot to get rid of her more distressing mental suffering. Alcohol is frequently a resort of such persons. Burns knew it when he sang:

> Kings may be blessed, but Tam was glorious,
> O'er all the ills of life victorious.

Whatever the act resorted to by the psychasthenic, he comes to crave it; for it relieves his suffering or tenseness or discomfort.

It may take the form of untimely or intemperate eating. Thus a woman who had a severe agorophobia would carry in her reticule an assortment of comestibles whenever she went out in the streets. To gain strength to cross the Rue de Bac, she would take a bite from a croisson; a piece of cheese enabled her to cross the Pont Neuf, but when she came to the Place de la Concord, its vast and

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terrifying distance compelled her to consume at least a fowl's wing before it could be compassed. The absurdity of this is no greater than that of the ticqueur who, by a simple touch of the finger to the chin, inhibits the powerful turning of the whole head in the torticollis movement which is his obsession. It is no more absurd than the imperative need of placing one's clothes in a minutely meticulous position on one's chair, and by requiring that they be turned in a certain way while dressing, so that the performance may require upward of two hours as occurred in the case of a young man which I have reported.

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MALINGERING. A PROBLEMATICAL CASE.

By WILLIAM C. SANDY, M.D.,
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The simulation of mental disease is rare, but cases of suspected or alleged malingering are met with, especially in medico-legal work associated with capital crimes. It is a rather common fallacy among the laity and the general medical profession that feigned insanity is of fairly frequent occurrence. Actual instances, however, are unusual and some psychiatrists may never see a single case.

The difficulties of simulation, alone, would seem to preclude, in most cases, the possibility of malingering. One will readily admit that neurotic symptoms may be assumed, those of a subjective nature, the evidence of existence of which depends largely upon the statement of the patient. Even such instances are less frequent than commonly believed. Single symptoms may be simulated or exaggerated, in the traumatic neuroses existing physical abnormalities may be falsely ascribed to the injury, suggestible hysterical individuals may imitate others and, as found in military life, a mentally diseased person may endeavor to simulate recovery in order to resume active duty. Insanity, however, as a prolonged departure from the patient's usual mode of thinking, acting and feeling is quite a different proposition. When the intensity of the excitement, the unceasing, restless activity, the prolonged period of sleeplessness and other characteristic signs of a manic condition, the deep and lasting depression with the diagnostic facies of a depressed state, the mannerisms, absolute change of personality, emotional deterioration or fixed delusions of a præcox, or the physical evidences of an organic condition, are considered, it seems doubtful that any of these could even be momentarily assumed without prompt detection by experienced psychiatrists.

Among the so-called prison psychoses, however, there are certain reactive disturbances of which the mode of onset, the symp-

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toms and course, may give rise to the suspicion of malingering. Especially is this true in those conditions which develop after the commission of a crime and while the prisoner is awaiting trial or execution. The patient may become acutely confused, hallucinatory, stuporous, catatonic, disoriented and show marked memory and intellectual defects or develop a delusional trend. Any of these may continue for an indefinite period but quite promptly disappear upon removal from a distasteful prison environment, pardon, or the occurrence of some equally favorable change. The onset of a psychosis and the rapid return to normal under such circumstances, places the psychiatrist in a delicate position and subjects him to the liability of considerable adverse criticism. At least some of the latter which surrounds the medical expert has resulted from a lack of appreciation of the existence of such psychotic conditions and the difficulties attendant thereon.

But some writers go so far as to state that simulation itself is an indication of mental disturbance, and it is certainly an abnormal method of meeting with difficulty. In this connection Kraepelin's statement in 1909 is apropos, *i. e.*, "as time passes, I have grown more and more conservative as to pure simulation, and I have seen a large number of my former simulators later become demented." It is generally true that fewer cases of suspected malingering are reported with the improving knowledge of psychiatry.

Moreover, malingering itself is simply often, if not always, a "defense reaction," and as such is allied to the psychoses, representing merely the effort of the individual to escape difficulty, an inadequate reaction to environment.

Illustrating the problems connected with the study of a condition manifesting some of the peculiar features of a prison psychosis, the following case history is presented.

The physical examination was conducted by Dr. C. A. West of the staff of the State Hospital for Insane, Columbia, S. C. Many of the observations were made in the company of Dr. J. Heyward Gibbes of Columbia, S. C., who was consulted by the prosecutor before the patient was transferred to the state hospital.

"X" is a white man, born in S. C. Age 38, married. Superintendent of an orphanage.

Family History.—The only evidence of insanity, nervous disease or other peculiarity in the family was the statement of the patient's father that the

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paternal grandfather had a fever and was queer for two or three years at about the age of 65.

He kept talking about a hog his son had bought, saying more or less constantly, "Seventeen dollars and twenty-one cents." His brother took him to the mountains where he "was put under a water spout and he immediately recovered."

Personal History.—The patient was the second child. His early development and childhood are said to have been normal. He began school at the average age and attended college two years, making his own way.

He was married about 13 years ago and has had one child, a girl now about nine years old. His married life is said to have been happy, but since he has become involved in difficulties, there has been a separation.

In disposition, he was friendly, sociable and affectionate. He made friends readily and was in a way a leader. He evinced considerable interest in religion, being a Baptist and having been a Sunday-school superintendent before he was 18 years old. He abstained from alcohol, tobacco and habit-forming drugs.

His usual occupation was farming, but he had been lately the superintendent of an orphanage conducted by a secret order. His father states that he had at one time planned to study medicine. He apparently showed laudable ambition, making his own way under difficulties.

Events Leading to Present Difficulty.—The patient had been in charge of the orphanage for about four years, occupying an honorable and influential place in the community. So far as the general public knew he was an exemplary citizen until one of the female inmates became pregnant, and, in the resulting investigation, it was learned that he had been having sexual relations for some time with a number of young girls. This revelation greatly aroused the feeling of the community, and he was arrested on May 30, 1912, being charged with rape, in South Carolina a capital crime.

While awaiting trial, he made his escape from the jail, perhaps through the assistance of outside parties. For a time his whereabouts remained unascertained although a reward had been offered for his apprehension. After some months, however, he was recognized by an acquaintance while attending church in Baltimore, the authorities notified, and in September, 1912, he was returned to South Carolina, where his trial took place in October of the same year. Upon his conviction he was sentenced to be electrocuted on December 20, 1912, being taken to the penitentiary and confined in the death house on October 27, 1912.

During the trial, his demeanor, from all accounts, appears to have been normal. He answered all question frankly and clearly, admitting his criminal acts, defending his wife from the imputation that she knew of his practises, and assuming all responsibility. Towards the close of his trial he made a personal appeal to the sympathies of the jury, well expressed, full of religious sentiment and stated to have been eloquently presented, apparently skillfully calculated to play upon their feelings.

Onset of Peculiarities (over one year before admission.)—Upon his arrival at the penitentiary and for some two years or more thereafter, he

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conducted himself, according to most informants, in a normal manner. One or two persons who observed him thought that he did not appear to appreciate the enormity of his crime. At any rate, he spent much of his time writing letters of instruction to his lawyers in regard to the appeal of his case. Later on, however, informants state he also began to write incoherent letters to the prison officials asking for various supplies and making complaints, showing considerable judgment defect. At the same time he wrote able letters to his lawyers. Still later, he got a basket of books with some yarn and appeared to be pretending the yarns were his pupils, teaching them, although still writing the letters to his lawyers.

About a year before admission he became mute, and after a trip to court for the purpose of being resentenced, he became negativistic, but continued to feed himself and was tidy, being taken to stool by another prisoner, until October, 1915. Dr. Gibbes had been observing him and had left orders that he should be let alone for ten days in an effort to arouse spontaneous action or break through the mutism. During that time (and since then until very recently) he had to be fed regularly and he constantly soiled himself, making no effort to care for himself.

It appears that the officials in charge, his fellow prisoners and physicians who observed him, quite generally regarded him as a malingerer, and many efforts were made to demonstrate this without success. Insanity being alleged by the defense, however, he was finally sent for an indefinite period to the state hospital for a thorough examination and close observation, being admitted on March 28, 1916.

Upon admission, he walked into the hospital in a peculiar, stiff manner, being assisted by the officers who accompanied him.

Physical Examination.—He would not cooperate in the physical examination and those parts requiring his assistance were exceedingly unsatisfactory. He was an undersized white man, height 4 feet 5 inches, weight 85 pounds. His hands and feet were very small. There were, however, no distinct malformations.

There was no evidence of an acute or chronic constitutional disorder except some enlargement of cervical and inguinal glands.

The pupils were normal in appearance and in reaction to light and accommodation.

There seemed to be a general anæsthesia to pain and temperature senses except that he showed after a time that he was uncomfortable when heat application or pin pricks were persisted in.

There were no vasomotor or trophic disturbances except some cyanosis of extremities.

Motor functions were not markedly altered except gait. He stood with feet wide spread apart, swaying from front to back, and when walking (usually only when led by the arm) he moved his legs in an awkward, stiff-kneed motion, not typically spastic.

The deep reflexes were about normal.

He apparently had no control over bladder or rectum.

Examination of chest and abdomen showed no abnormality.

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He would not feed himself, but apparently had a fair appetite, eating when food was carried to his mouth.

The urinalysis, blood serum and spinal-fluid Wassermann, spinal-fluid Globulin reaction and cell count were all negative.

Mental Status.—For about a year the patient remained the same as on admission. He was placed in bed and kept under constant observation. He would lie quietly in bed, usually on his right side in a huddled-up way, arms and hands partially covering head, eyelids almost closed as if covertly watching surroundings. When aroused, as by shaking him by the arm, raising the eyelids or some other act in an endeavor to get his attention, he would sit up in an awkward way, eyelids still almost closed, and putting his hands in front of him begin to go through a peculiar movement, bringing the fingers together with a slight rubbing motion. He would keep this up for an indefinite period, if his hands were held making a strong resistive effort to resume it. If his supra-orbital nerves were pressed upon, his head percussed or something else done which seemed to cause him annoyance, he would raise a hand in a machine-like, wax-figure way and brush away examiner's hand, again going through the stereotyped movements. He would not talk or show by any outward sign that he heard or understood what was said in his presence. He soiled himself, never using a vessel which was within reach, on one or two occasions, however, getting up and urinating on the floor. He would not assist himself in eating, although a tray was often left with him. The attendant would have to place the food to his lips, when he would grab it with both hands, stuffing it in his mouth and eating in a voracious manner. In drinking, he would grab the cup in both hands after it was placed to his lips, and, biting at the cup, quickly empty it of its contents. It was never necessary to tube feed or force feed in the ordinary sense.

When put on his feet on the floor, he stood with legs wide apart, swaying unsteadily. He would not take a step unless led or pushed forward when he would suddenly start, walking a few steps in a stiff-kneed way acting as if about to fall and finally leaning up against the wall or bed when he would resume the same stereotyped movements. He would continue to keep his head bowed and his eyelids partially closed. He never showed even a tendency to retain saliva.

When lying in bed, he assumed a not unnatural and comfortable position. On one occasion, when observed without his knowledge, he was seen to raise himself up on one elbow and look about with his eyes open in a rather natural way, but although watched carefully at different times he never otherwise changed from the demeanor already described.

Being under sentence of death and merely at the hospital for observation, every effort was made to demonstrate the presence or absence of malingering. The administration of an anæsthetic, the production of intoxication, the application of electricity and other means failed utterly to break through the mutism or to alter his general attitude.

The visits of his father and former acquaintances, and conversations about his case or his family in his presence did not alter his pulse rate or otherwise indicate that his attention had been gained.

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For just a year, he continued essentially as described, the only change being that he seemed less inclined to make the stereotyped motions but rather preferred to lie quietly in bed. A recurrent manic patient on the same ward went to his room upon several occasions and in loud, boisterous tones told him that he had nothing more to fear, his sentence had been commuted and he was now in a hospital for the insane. At the same time, he (the manic patient) put him through vigorous motions, twisting about his head and extremities. Whether or not this had any bearing on the subsequent events, he began to talk and pay attention to conversation and his environment on March 27, 1917.

In appearance, he now seemed dazed, confused, talking in short sentences and as if figuratively speaking. His first words were, "I am alive. I was dead in that sea." He called the place a hospital, but added, "A ship." They left me behind that rock. The horses were running away." Asked if he remembered coming to the hospital, he said, "It's all dark on the field. I waked up. I am alive. I waked up. I don't know when it started—on that battlefield—behind that rock when they ran over me." He talked slowly and in short sentences as if reflecting or unravelling a hazy mystery. After being silent for some time, he said spontaneously, "I am not dead;" and later, "I saw myself in the bottom of the sea; I don't know how I got here." He knew his name. He said his wife was dead. When asked about being in prison, he said, "Prison—I—was—in prison. That was before the war. That's dark."

When told to stand up, he at first said he could not, but when urged to do so he stood in the same unsteady way with legs wide apart. He said, "I don't want to fall. World shakes. I can walk. Shakes." When asked directly if he had been connected with an orphanage and if he had assaulted a child he said, "That was on the other side." When asked his age, he said, "I'm not old. I was just 15 when the war broke out."

Following this, he has gradually improved in personal appearance, has become tidy, dresses and feeds himself. He has learned the names of those with whom he is constantly associated and seems to be taking in his environment. He still talks as if coming out of a dream or trance-like state and has said that he felt "weird, stupid and dreamy." He said, "If I could just get loose from it, I could feel the world was a reality. It seems like a dream. I don't know how many brothers I had. I can see them in a group. They are veiled, however—a little more than shadows in my mind."

Asked how old he was when married, he replied, "I might have been 25 years old. I can't tell exactly. I can't get time straightened out. It seems strange; I try to live in the present. It draws me when I try to get back and fill them up. It may come."

As if soliloquizing, he said, "I think I would know them if I should see them. My wife—my wife—her name was Ella." (as if the name just occurred to him.)

Asked if he had a child, he replied, "Yes," but as to whether a boy or girl, "I am uncertain, only one—a baby—I can't recall. Now I know. Her name is Ruth. That's her name. I have been trying to think—and my

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wife's name is Ella. Just one child, I think. A little girl. Ruth is her name. I feel certain. I've been trying to think of them."

He has been reading his Bible, being especially interested in the Psalms. When asked if he wanted the papers, he said, "No. They would not interest me. I have my Bible. I want to read it. I can't read much. It is very painful. I soon come across a word I can't recall. I want to get my mind to working."

He spoke about not having any emotions, and wondered at this because he was not dead.

When asked if he ever heard voices, he said, "Sometimes, but not as bad as they were. They are not distinct—like waters roaring. They are all distant—talking through water. They are not talking to me. They are all mixed up."

On May 18, he showed the same general characteristics. When asked about events in his past life, such as the dates of his birth and marriage, he claimed that he was unable to recall these. He said, "Some things seem to stand in a general way. I am close to them but I can't get them. It worries me. It draws me. I don't think it is good for me to look at them. It is painful at times to try to hunt them up. I don't know when the darkness came upon me. There is no place I can tell. There is not a single place that I can say, 'This is the last thing I can remember.' I know when I came to. I saw light that morning. I remember when I waked up. I heard a noise as if going through space or a whirr as if speeding through water. Then I opened my eyes."

He was approximately oriented. He knew the name and nature of the place. At first he said he did not know the name of the state but later on recalled it. He said the present month was April. Could not give the year.

He could not recall the name of the President of the United States or the governor of the state. He knew nothing of current events.

He recalled a few historical facts. For instance, he knew Columbus discovered America. In the conversation about this point he spontaneously said, "1066." Asked what he meant, he said, "That date came to me. Something about the French. No, it was England."

He apparently had lost his calculating ability to a certain degree.

$6 \times 8 = 32$ $4 \times 3 = 24$ $2 \times 4 = 8$
$3 \times 4 =$ "16—no, it is twelve."

He showed a certain amount of insight. He recognized the mental abnormalities of those about him. In discussing these, he said, "They are not affected as I am. They are restless, moving about."

Questioned about his life at the orphanage, his arrest, trial and so forth, he again stated he recalled very little. He admitted remembering having held a position at an orphanage and some trouble with the little girls, but he said it was all hazy and indistinct.

At the time of the last interview, he still had the staring expression but less marked. There was anæsthesia of the pharynx; otherwise physical condition being apparently normal.

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Summary.—Before commenting further upon this case and endeavoring to draw any definite conclusions, the salient features will be emphasized in a brief recapitulation.

Presenting no well-defined nervous or mental heredity, with an apparently normal early life, married, successful under disadvantages, respected and to a degree influential, the patient, at the age 35, was found to have been having sexual relations with young girls, inmates of the orphanage of which he was the superintendent. While awaiting trial, he escaped, being finally apprehended in Baltimore, where, it is alleged, he attended medical lectures for a short time. At his trial, he admitted his fault, made a strong personal plea to the jury and later advised with his lawyers in regard to an appeal. Being finally convicted and sentenced to death, he first began to write occasional incoherent letters, then to collect books and yarns, apparently regarding the latter as pupils he was teaching. He continued to write able letters during the early part of this change in demeanor. About a year before admission, he became mute, and negativistic and later on had to be fed. He also became indifferent as to personal habits, regularly soiling himself. In this condition, he was placed in the state hospital under observation. The physical examination was practically negative. Mentally, besides the above characteristics, he showed peculiar mannerisms, fumbling with his hands, standing with legs wide apart, walking if led with a stiff-kneed wax-figure-like gait, eating only if food was placed to his lips and then grabbing it and stuffing it in his mouth in a voracious manner. After a continuation of these symptoms with no perceptible change for a year, he suddenly began to talk, became tidy, dressing and feeding himself, and began to show interest in his surroundings. His conversation and facial expression seemed to indicate confusion and uncertainty, and there seemed to be amnesia for much that had occurred since his arrest and general loss of memory. He now seems to be gradually regaining the latter, but is disinclined to talk or think of the past, saying it is painful. He states that he has heard voices, "distant as if through waters;" also that the world seemed unreal and everything shadowy. Physical condition apparently normal aside from anæsthesia of pharynx.

Comment.—The mode of onset, to judge from the statement of others, would seem in a way to speak for simulation. While ad-

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vising with his lawyers and writing to them letters of instruction which showed no evidence of mental abnormality, he sent at the same time incoherent and foolish letters to the prison authorities. (Statement from latter.) The collecting of books and yarns and teaching the latter, as reported by informants, do not resemble the characteristics of a typical psychosis. Neither are the mutism and resistiveness coupled with such usual symptoms that a diagnosis may be made. On the contrary, the peculiar voracious mode of eating when food is placed to his lips, the stiff gait with legs widespread, the fumbling with the fingers, make it difficult to reach a satisfactory conclusion.

A discussion of the content of his ideas, as shown by his conversation, of probable psychoanalytic significance and interest, will not be entered into.

The persistence of the mutism and generally peculiar attitude in spite of all effort to break through the same led the writer finally to report that the man was insane, the condition being allied to dementia præcox. Upon the strength of this it was decreed by the court that the patient be held at the hospital for an indefinite period or until he became normal mentally. This diagnosis was made with the full realization that the symptoms might disappear upon a change of environment or improvement in his legal status. Since then, the marked improvement and apparent gradual approximation towards the normal have not, in the writer's opinion, made necessary a revision of this diagnosis. The hysterical-like amnesia (associated also with symptoms resembling the Ganser syndrome) with a suggestible anæsthesia of the pharynx is not incompatible with a psychosis of the præcox variety, and the mechanism must be considered a defense against disagreeable reality.

Even if the condition began as malingering, it is a question, having continued so long in such an unnatural attitude, whether or not he could "come back" and resume his former status.

Whatever the outcome, many of the symptoms and the course resemble a "prison psychosis," so much so that the writer feels fully justified in giving the prisoner the benefit of the doubt.

The case is of further interest as to the ultimate outcome, when the question of final disposition may arise should he reach an apparently normal mental state.

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DISCUSSION.

DR. CARLOS MACDONALD.—Mr. President, as the hour is so late, and we are so near the close of the session, I shall be very brief in the few remarks I desire to submit in the discussion of Dr. Sandy's paper.

One of the popular delusions of the day, if I may so term it, is that the plea of insanity—the so-called "insanity dodge"—is frequently successfully used in the defense of sane criminals. While it is true that a trumped-up defense of insanity is frequently offered in criminal cases, especially in those in which there appears to be no other avenue of escape, the fact is that a dishonest plea of insanity very rarely succeeds. During an experience of nearly 40 years in the observation of such cases, I have personally known but two instances in which a sane criminal escaped conviction on the plea of insanity.

As to whether a lawyer is ever justified in defending a criminal on the ground of insanity when he knows said criminal is perfectly sane is an ethical question which may properly be left to the legal profession—though I venture to say that lawyers have been disbarred for offenses of lesser gravity than that.

Superintendents of institutions for the criminal insane are agreed that very few criminals are wrongfully adjudged insane and committed to their institutions. This accords with my own experience of nearly 13 years as superintendent of the hospital for insane criminals in the state of New York. On the other hand, it is undoubtedly true that 10 insane persons are convicted and sent to prison to one sane criminal who escapes punishment on the plea of insanity.

It is a prevalent notion that it is an easy matter to simulate or feign insanity successfully. The fact is that one could scarcely undertake a more difficult rôle.

To succeed in shamming insanity, so as to deceive a skilled observer, one would require not only to be a consummate actor, but to be well versed in the symptoms of the different forms of mental disease, and to possess unusual powers of endurance. The average criminal, being entirely ignorant of the symptoms of insanity, usually over-acts his part and fails to present a consistent clinical picture of any form of that disease. The "symptoms" he presents to the eye of an experienced alienist are usually a medley of symptoms in which he mixes up the various forms of insanity indiscriminately. Furthermore, his "symptoms" subside as a rule, when he believes he is not under observation. Also the symptoms are apt to become more active as the time of trial approaches. I have no hesitancy in saying that it is practically impossible to simulate insanity so as to deceive a skilled observer, provided the latter has sufficient opportunity to observe and test the case.

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MEMORIAL NOTICES.

DR. WILLIAM MABON.

All who are interested in the care of the insane in the state of New York were shocked and deeply grieved when on the morning of February 9 they learned of the sudden death of Dr. Mabon. He had been in the fullest enjoyment of health up to the time of his fatal sickness, and it was difficult to believe that one so full of energy and strength could be so suddenly taken from us.

Dr. Mabon was born in New Durham, N. J., in 1860, and was therefore 57 years of age. He was the son of Rev. W. V. V. Mabon, for many years professor in Rutgers College, under whose guidance his early education was obtained. His medical training was received in the Bellevue Hospital Medical College, from which he was graduated in 1881. After graduation he served as house physician and surgeon in the Jersey City General Hospital, and later became an assistant physician in the State Hospital for the Insane at Morris Plains, N. J., where he remained from October, 1885, to March, 1887. At the latter date he began what proved to be his life work, by becoming an assistant physician in the Utica State Hospital. He passed through the various grades on the Utica staff, and in 1895 was elected to the superintendency of the Willard State Hospital. He remained in this position for about a year, when he was called to the superintendency of the comparatively new institution at Ogdensburg. The development of this institution upon the most advanced lines was due, in a great measure, to Dr. Mabon's original and creative mind.

His success as an administrator having attracted the attention of the New York City authorities, he was asked, in 1903, to assume the superintendency of the Bellevue and Allied Hospitals. His success in this new field was marked, but in 1904 his love for psychiatry induced him to return to the state service as president of the State Commission in Lunacy, where he remained until 1906. In that year Dr. Mabon was called to the superintendency of the Manhattan State Hospital, on Ward's Island, which was then rapidly growing to be an immense metropolitan institution with a population which later rose to over 5000 patients, the

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largest hospital for the insane in the world. He remained at this post until the time of his death.

Dr. Mabon's extensive experience made his advice and cooperation extremely valuable, and his counsel was constantly sought by governors, legislators, philanthropists and social workers in this and other states. From the time that he was commissioner he exercised a powerful influence on the state's policies in dealing with mental disorders, and he was constantly an active supporter of all endeavors made in the state to advance scientific work in psychiatry. His connection with many famous trials gave him a national reputation as an expert, and his efforts to improve the condition of the feeble-minded and insane were recognized and felt in all parts of the country. In consequence of this signal usefulness he was one of the most conspicuous figures among the psychiatrists, not only of New York State, but of America.

He served as consulting physician to the Medical Board for the Department of Atypical Children, on Randall's Island; and as Consulting Alienist to the Hospital for Deformities and Joint Diseases, to the Neurological Institute, and to the Red Cross Hospital, all of New York City. For many years he was professor of psychiatry in the New York University and Bellevue Hospital Medical College, and an active member of many medical societies, such as the New York County and the State Medical Society; the New York Academy of Medicine; the New York Psychiatrical and the New York Neurological Society, and the American Medico-Psychological Association.

In the National Committee for Mental Hygiene he was for some time a most active member of the Executive Committee, and had much to do with the shaping of the policy of this body.

Dr. Mabon possessed a most engaging personality and his influence was impressed upon all who came in contact with him. In his work he combined a constant vision of the larger issues in psychiatry with an extraordinarily incisive and ready judgment in all matters. To these traits, together with his optimism and steadfastness of purpose, his marked success was largely due.

It is not too much to say that practical psychiatry lost one of its most eminent exponents, the state one of its most faithful servants, the dependent insane one of their most earnest champions, and his associates one of their truest friends when Dr. Mabon died.

CHARLES W. PILGRIM.

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DR. CHARLES HAMILTON HUGHES.

Dr. Charles Hamilton Hughes was born May 23, 1839. He graduated in the St. Louis Medical College in 1859, and at once entered Marine Hospital, St. Louis, Mo. He enlisted in the United States Army in 1861 as major and surgeon. Was stationed in several of the military hospitals during the late Civil War, receiving his discharge in 1865. Immediately thereafter he was appointed superintendent of State Hospital No. 1 for the Insane, at Fulton, Mo., filling this position with much honor for five or six years. Since that time he was actively engaged in his specialty; that of nervous and mental diseases. He was connected with several of the St. Louis schools as a lecturer and professor of neurology and psychiatry. He was well and favorably known throughout the United States and in many parts of Europe. He was a strong advocate. He did much to elevate the standard of medicine and especially to improve the care and treatment of the insane. He founded the *Alienist and Neurologist* in 1880 and was its publisher and editor, until the time of his death. This journal is still being published and is a monument to his memory. He was president of the Mississippi Valley Medical Society in 1891. Was a member of the judicial council of the American Medical Association. He was chairman of the Section of Nervous and Mental Diseases of the American Medical Association when it convened in San Francisco. He was an active member of the American Medico-Psychological Association for many years. He was an ardent worker in the Missouri State Medical Association, and was an honorary member of the British Medico-Psychological Society, also a foreign member of the Russian Society of Neurology and Psychiatry. He died March 3, 1916.

C. R. WOODSON.

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DR. R. W. BRUCE SMITH.

Dr. R. W. Bruce Smith was born in 1857 and died March 28, 1916. He was a man of kindly disposition and excellent executive ability, who did a great deal to advance the hospital situation in the Province of Ontario. During his régime hospital expansion was marked and he was intensely anxious to have Ontario stand well in the eyes of the world. It was largely through his advice that the present Ontario Hospital Act, which is acknowledged as one of the best things of the kind in existence, was placed on the statute book, and through his foresight, hospital maintenance became a much simpler problem than ever before in the history of the Province.

Dr. Smith had the faculty of placating enemies and getting through life with as little friction as possible—the result being that he succeeded where many other men have failed. At the same time he was firm in dealing with situations which required a strong hand, and through his instrumentality jails were relieved of the burden of caring for insane prisoners, and insane people were freed from the stigma which necessarily attached to their being incarcerated in institutions which were primarily built for the detention of criminals.

Dr. Bruce Smith really did a great work in the Province, and had he lived to carry out many of the reforms that were in his mind, would have occupied even a more prominent position in the history of the Province. It was his intention if possible to improve the nursing situation and on several occasions he endeavored to establish registration without accomplishing his object owing to the rooted opposition of certain groups who were not fully in sympathy or really understood what his intentions were.

Dr. Smith was fully in touch with the great humanitarian problems of th · age, and was always very active in his cooperation with true reformers and aided them in every way possible.

His death came at a most inopportune moment and left the situation very much muddled, as it will be difficult to find a man to follow in his footsteps.

CHARLES K. CLARKE.

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DR. ELIOT GORTON.

Dr. Eliot Gorton died of pneumonia at Summit, N. J., on March 3, 1917, after an illness of about 10 days. He was born at Newburgh, N. Y., July 26, 1863, and lived with his parents during most of his childhood, in Brooklyn, N. Y., and after finishing his preliminary education at Norwich University, Vermont, he entered upon the study of medicine at the Long Island College Hospital, from which he graduated in April, 1888.

The following June he was appointed fourth assistant at the New Jersey State Hospital at Morris Plains, N. J., at which institution he immediately entered upon his duties, serving for a period of eight years in the capacity of first assistant physician, from which position he resigned July 1, 1902, to open Fair Oaks Sanatorium at Summit, N. J., for the care and treatment of nervous diseases. Dr. Gorton's essential kindliness won for him many friends; he was untiring in his devotion to his friends and an ardent champion of the things that are right, and all who knew him quickly recognized his basic honesty as one of the chief virtues of his character.

Dr. Gorton was married on September 12, 1888, to Miss Bertha Fonda of Fonda, N. Y., and is survived by a widow and one son.

THOMAS P. PROUT.

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DR. CHARLES FREDERICK GILLIAM.

Dr. Charles Frederick Gilliam, superintendent of the Columbus State Hospital, died at that institution April 12, 1916, from injuries received in an automobile accident. He was born at Logan, Ohio, in 1854, the son of William and Mary Gilliam.

When 12 years old he was forced to leave school and to secure work in a nail factory to help in the support of his family. He later was employed in iron mills and as a drug clerk. He studied medicine with his brother, Dr. D. Todd Gilliam, and in 1878 graduated with honors from the Columbus Medical College, afterwards taking postgraduate work in the medical department of Columbia University. He spent some time in Washington, D. C., first as clerk to the Committee on Pensions in Congress, then as special agent and statistician in the United States Department of Labor, and finally as chief of a division in the Interior Department.

In the early 90's he resided at Newport News, Va., and was active in the organization of that place into a city corporation. He returned to Columbus, Ohio, in 1896, and continued to be interested in civic and medical affairs.

During his incumbency as superintendent of the Columbus State Hospital the institution made marked advances along the lines of internal development. Many wards were remodeled and large sun porches erected. A well-equipped recreation hall was opened for both patients and employees. The connecting doors in many wards, as well as those of the sleeping rooms in the wards, were removed.

Early in 1914, by request of the Ohio Board of Administration, he prepared a large exhibit of pictures and charts giving views and statistics of the 18 institutions of the state. These charts, referring to methods of treatment, admissions, discharges, types of mental diseases, cost of maintenance, etc., were shown at the meeting of the Ohio State Medical Society and of the American Medico-Psychological Association at Baltimore.

He made many contributions to medical and popular literature, and wrote verses and short stories for magazines and periodicals, and two novels. He was a member of the local, state and national medical associations and took an active interest in their welfare.

His administration of the state hospital was characterized by a feeling of good will between himself and his patients and employees by reason of his kindly nature.

GUY H. WILLIAMS.

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DR. RICHARD H. PARSONS.

Richard H. Parsons, M. D., one of the best known and most active physicians of Burlington County, N. J., died at Mercer Hospital, Trenton, on November 11, 1916, from pneumonia. He had been in ill health for several months, and had gone to the hospital for treatment for nervous troubles. A few days after entering the hospital, he contracted pneumonia, and his weakened condition could not withstand the ravages of that disease.

Dr. Parsons was a son of the late Charles B. and Jane C. Parsons, and was born in Mount Holly, N. J., on September 9, 1859. His early education was obtained in local schools in Mount Holly, after which he took a course at the Moravian School at Nazareth, Pa., and in the medical department of the University of Pennsylvania, graduating in 1880. He immediately began the practice of medicine in his native town of Mount Holly, and continued actively in his profession there until a few weeks prior to his death.

Besides attending to a large and lucrative private practice, Dr. Parsons held a number of important public positions. At the time of his death he was superintendent of the Burlington County Hospital, at Mount Holly, a position he had filled acceptably and creditably for 32 years; he was physician to the Burlington County Hospital for the Insane, at New Lisbon, N. J., from the time that institution was founded until the time of his death, a period of about 15 years; he was medical inspector of the Mount Holly public schools from the time that office was created until the time of his demise, covering about 12 years; and he was sanitary inspector for the Mount Holly Board of Health, a position which he also had held for many years.

These positions gave Dr. Parsons an extensive acquaintance throughout his home county and among medical men and specialists throughout Southern New Jersey and Philadelphia.

He kept abreast of the times in his professional work, and was acquainted with modern methods employed in the variety of work with which he was connected.

At the time of his death, Dr. Parsons was a member of the New Jersey State Medical Society, the American Medical Society, the American Medico-Psychological Association, Burlington County Medical Society, the New Jersey State Sanitary Association, and

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a member of its executive council, and of the Philadelphia Medical Club.

Aside from his profession, Dr. Parsons was quite active in secular affairs. He was a director of the Union National Bank of Mount Holly; of the Mount Holly Trust Company; president of the Mount Holly Building and Loan Association; and also was a vestryman of St. Andrew's Protestant Episcopal Church of Mount Holly. He was a member of the local lodges of Elks, Masons and Odd Fellows; a member of the Burlington County Historical Society, and of the historic Relief Fire Company of his town.

He is survived by a widow and a daughter.

BRITTON D. EVANS.

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DR. CARL VON ARX SCHNEIDER.

This tribute to a departed member of our Association might well begin, like Dante's immortal poem,

"In the middle of life's way,"

for it was but a little more than midway in life, in the early prime of a successful and honorable, medical and official career, that relentless death ended the earthly existence of Carl von A. Schneider.

Born of a vigorous Swiss ancestry, at Fredonia, N. Y., on August 31, 1879, he was one of a family of six sisters and four brothers. In Canton, Ohio, whither the Schneiders later removed, Carl acquired a high school education, and resolved to devote his life to the practice of homeopathic medicine.

Graduating with high honors from the Cleveland Medical College in May, 1904, he spent a year there as lecturer on anatomy and another year as interne in the Cleveland City and Huron Road Hospitals.

Partly from natural inclination and partly at the solicitation of an intimate friend, Dr. J. R. Horner, he then turned his attention to psychiatry and joined the staff of the Gowanda State Homeopathic Hospital on August 1, 1906. Here he speedily developed a special aptitude for institutional service and rapidly gained promotion to junior assistant in 1908, second assistant in 1910, senior assistant in 1912, and finally to first assistant physician in October, 1914, in which position he seconded Superintendent C. A. Potter with marked ability and faithfulness. In the treatment of both physical disease and mental infirmity he proved eminently capable, and the manifold difficulties of executive management he overcame with equal success. Discretion, sound judgment and unfailing kindness of heart gained him the confidence and good will alike of his staff associates and of the many hundreds of patients under his jurisdiction.

Attacked by typhoid fever during holiday week, the best of care proved unavailing, and on Sunday morning, January 28, 1917, his many anxious friends were shocked to hear of his death. He was buried at Canton, Ohio, and thus ended a brilliant progress which, if not so untimely checked by death, would doubtless have carried Carl von A. Schneider to a very high place in the psychiatic branch of his chosen profession.

C. A. POTTER.

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DR. MOSES JAMES WHITE.

Dr. Moses James White died on the 14th day of March, 1917, at his home in Hartford, Conn. Doctor White had made his home in Hartford, since his retirement from the superintendency of the Milwaukee County Asylum, to be near and to care for his aged mother.

He was long and favorably known to the members of the American Medico-Psychological Association as the Superintendent of the Milwaukee County Hospital for the Insane, which although belonging to the municipality of Milwaukee, took rank with state institutions in all respects. Dr. White had served a long and most creditable term in the above institution, having entered upon his duties in January, 1887, as assistant superintendent and succeeded to the superintendency in June, 1888. Over a quarter of a century Doctor White presided with success and distinction in the Milwaukee Institution, and his retirement at the end of 1916 was largely the result of political changes, as the performance of his duties had been competent and skillful.

Aside from his administrative duties Doctor White was especially interested in developing industries among the patients, promoting salutory amusements as a part of their treatment. He also prepared and published papers on the "Prevention of Insanity" and "Provision for the Insane Awaiting Commitment." He also perfected an invention of value for opening the doors of the locked patients' room by an electric device which would be available in case of fire or panic. This system was successfully installed in his own institution. He also was among the early introducers of congregate dining-room service.

Doctor White was the son of a physician who practiced in Hartford, Conn. He had three brothers likewise physicians, all the natives of the north of Ireland. Doctor White was born at Hartford, Conn., February 28, 1860, and was educated at the high school, later taking an academic course at Princeton University and a scientific course in La Fayette College, Easton, Pa. He graduated in medicine from the University of the city of New York in 1884, and until his appointment to the position in Milwaukee in 1887, was successively junior and senior assistant physician to the New York City Asylum, now known as the Manhattan State Hospital.

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Doctor White was a member of the Milwaukee Club, of the Deutscher Club of Milwaukee, held a prominent position as a Free Mason in the Kilbourn Lodge of Milwaukee. He was also a member of the American Medico-Psychological Association. He was a member of the Protestant Episcopal Church.

He married in 1886 Miss Lizzie Ella Lownes of New York City. He is survived by his widow and one son, Reginald James.

Doctor White's last resting-place is Milwaukee's beautiful "Forest Home." His funeral, held in Milwaukee under the auspices of his Masonic brethren, was largely attended by his extensive circle of life-long associates and friends—personal, professional and official.

RICHARD DEWEY, M. D.

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DR. GEORGE HAMILTON SCHWINN.

Dr. George Hamilton Schwinn was born January 11, 1873, in Baltimore, received his preliminary education in the public schools of that city, and graduated from the Maryland College of Pharmacy in 1894. He then came to Washington and entered the Columbian University Medical School, now known as the George Washington University, graduating in 1898. Shortly thereafter in July of that year, he was appointed Clinical Interne in the Government Hospital for the Insane under the late Dr. Godding. Gaining promotion step by step, in January, 1911, he succeeded the late Dr. Stack as first assistant which position he held until his death.

In 1902 he married Miss Elvira Gaddess of Washington, D. C. His wife and twin sons, George Hamilton and Gordon G., born in 1904, survive him.

In the spring of 1914 Dr. Schwinn's health became much impaired. He was confined to his bed several weeks, and as soon as be was strong enough to travel he went to Saranac Lake, N. Y., where he spent the summer. The rest and treatment there greatly benefited him, and he returned to his duties at the hospital early in November buoyed up with the hopes of an ultimate cure. The following spring, however, the appearance of certain symptoms alarmed his family and friends, and in July, 1915, he went to the foot hills of the mountains near The Plains, Va. The summer spent there proved of little benefit, and much discouraged he felt it incumbent upon himself to return to his duties. It was now evident that his malady was firmly established. He clearly appreciated the outcome, and with never a murmur of complaint, against the advice of his friends, he endeavored to keep up with his work when it was to be seen that his health suffered in consequence. In January, 1916, his illness assumed a more acute form. He grew rapidly weaker, and with pathetic patience he awaited the inevitable end, which came February 6, 1916, in his apartments in the hospital.

Doctor Schwinn was first of all a man of the highest honor, and in this trait of character were embodied all its attributes. He was a devoted and self-sacrificing husband and father, a faithful and generous friend. Serving his entire practice of nearly 18 years in the Government Hospital for the Insane, he was the ideal type of

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institutional physician, ever loyal to the hospital, patient, sympathetic, gentle in speech, and noted for the deep and personal interest he took in his patients and their friends. Of these latter there came to his bier many who in sorrow told of their loss and of the deep gratitude they owed to the man who ever patiently by the hour listened to their woes, adjusted their difficulties and sent them home with a sense of peace and comfort.

Doctor Schwinn was the author of the following: "Some of the Difficulties Encountered in Making a Diagnosis of Paresis," The Journal of Nervous and Mental Diseases, December, 1910, XXXVII, 754-764; "Prognosis and Therapy of Cerebral Syphilis," The Journal of the American Medical Association, 1913, LX, 1852-1855 (read before the Society for Nervous and Mental Diseases of Washington, D. C., at a Symposium on Syphilis of the Central Nervous System held March 20, 1913).

ALFRED GLASCOCK, M. D.

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